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## The Enforceability of Releases in Property Insurance Claims

Jay M. Feinman

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## THE ENFORCEABILITY OF RELEASES IN PROPERTY INSURANCE CLAIMS

JAY M. FEINMAN\*

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*This article discusses the contexts in which disputes arise over the execution of liability releases by the property holder in the course of settling property loss claims. The article analyzes two conflicting interpretations of these disputes, each of which yields a markedly different result. The article explains the nature of this conflict, rooted in principles of contract law and insurance law, before outlining the arguments favoring full indemnification for the claimant and the counter arguments for the insurer in seeking to avoid additional liability. Put another way, the public policy interest in the full payment of insurance claims is pitted against the insurer's interest in the final resolution of disputes. The article concludes by siding with the claimant in arguing that most releases, should they be deemed enforceable, actually encourage improper claim practices and, as such, should be held unenforceable as a matter of public policy.*

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A property owner suffers accidental damage to its property and makes a claim for the loss under its insurance policy. The insurance company sends an adjuster to determine whether the loss is covered, scope the damage, and estimate the cost of repair. The adjuster and the owner inspect the property and discuss the issues, perhaps with the assistance of experts. The adjuster offers an amount to settle the claim and the owner accepts payment of that amount. In some but not all cases, the adjuster may ask or require the owner to execute a release as a condition of payment. Subsequently the owner discovers that the assessment of the loss at the time payment was made failed to account for all of the damage for which it was entitled to indemnity under the policy. The owner files a claim with

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\* Distinguished Professor of Law and Member of the Rutgers Center for Risk and Responsibility, Rutgers School of Law, Camden.

the company for additional compensation, and the company proffers the release as a defense to any further liability. Is the company obligated to pay, or does the release bar any further claim?

The answer to this question illustrates a common situation in insurance law. The answer begins with an ordinary contract law doctrine—the pre-existing duty rule. But insurance law is not simply contract law,<sup>1</sup> and the application of the pre-existing duty rule implicates two potentially conflicting policies and two different interpretations of the underlying facts. The nature of insurance is to provide full compensation for covered losses, which favors the owner's further claim, but the public policy favoring the final resolution of disputes and the enforcement of settlements agreed to favors the company's attempt to enforce the release. Which of these policies is most salient in a particular case depends on whether the process yielding the payment is seen as part of the fluid process of adjusting the claim, in which case the process is not final at the point of payment and the release is not enforceable, or as the resolution of a dispute about the amount the company owes, so that the release is binding.

This article discusses the contexts in which disputes such as this arise and the rules and policies that determine whether and when releases in those contexts are enforceable. Part I of the article explains the process of adjusting property losses and how releases are sometimes used in that process. Part II discusses the application of the pre-existing duty rule to this process. The rule makes a release ineffective unless it is given as part of the resolution of a good faith, genuine dispute between insurer and insured; in the ordinary case of adjusting a loss there is no good faith, genuine dispute so a release is unenforceable. Part III addresses issues of public policy. It concludes that the application of the pre-existing duty rule to releases in ordinary property loss adjusting situations is supported by the strong public policy favoring the payment of insurance claims in full, and the public policy favoring the settlement of disputes is not relevant in those situations.

## I. RELEASES IN PROPERTY INSURANCE CLAIMS

When an insured under a homeowners' policy or other property policy suffers a loss potentially covered by the policy, the formal steps in

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<sup>1</sup> "What do they know of the law of the insurance contract who only the law of contract know?" EDWIN H. WOODRUFF, *SELECTION OF CASES ON THE LAW OF INSURANCE* 5 (2d ed. 1924).

adjusting the loss are outlined in the policy itself. Under the HO-5 homeowners' policy, for example, the policyholder must give the company prompt notice of the loss, keep an accurate record of any repair expenses, cooperate in the investigation of the claim, prepare an inventory of and document the loss of personal property, submit to an examination under oath, and submit a proof of loss.<sup>2</sup> The company may not require the policyholder to perform every duty in every case, such as submit to an examination under oath, and other duties may be required in particular circumstances, such as reporting a theft loss to the police. The company has fewer specified duties in the event of loss. If the parties fail to agree on the amount of loss, either may demand an appraisal to which the other party must submit.<sup>3</sup> Ultimately, the company has a duty to pay for a covered loss within sixty days of agreement with the policyholder, appraisal, or judgment.<sup>4</sup>

The formal steps outlined in the policy are only the skeleton on which the body of property loss adjusting is constructed. Once the policyholder reports a loss, the policyholder and the company jointly embark on a process of investigating and verifying the facts of the loss and the extent of coverage for it.<sup>5</sup> Investigating the facts and verifying the loss in turn require determining the scope of damage and pricing the costs of repair or replacement.<sup>6</sup> The policyholder may be assisted in the process by a public adjuster or an attorney, and the company may be represented by its own claims personnel or an independent adjuster. Either or both parties may call on contractors, engineers, or other experts to provide technical assistance in scoping and estimating the claim, and on lawyers in interpreting the policy.

Sometimes the policyholder and company are unable to reach a satisfactory resolution of the claim and litigation ensues. In the overwhelming majority of claims, however, the parties arrive at a mutual understanding on the extent of the covered loss and the amount needed to indemnify the policyholder, and the insurance company pays the claim. The company may simply pay the claim or it may accompany the payment

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<sup>2</sup> *Homeowners 5 – Comprehensive Form*, NEV. DEP'T OF INS. 13 (1999), [http://doi.nv.gov/scs/HomeownersPolicyForms/HartfordForms/Hartford\\_HO\\_00\\_05\\_10\\_00.pdf](http://doi.nv.gov/scs/HomeownersPolicyForms/HartfordForms/Hartford_HO_00_05_10_00.pdf).

<sup>3</sup> *Id.* at 15.

<sup>4</sup> *Id.*

<sup>5</sup> 1 PROPERTY LOSS ADJUSTING 209 (James J. Markham ed., 2d ed. 1995).

<sup>6</sup> 2 PROPERTY LOSS ADJUSTING 1 (James J. Markham ed., 2d ed. 1995).



with a request or demand that the policyholder execute a release, even though the policy does not require that the policyholder execute a release as a condition of payment.

In many cases, the amount paid to the policyholder is sufficient to effect repair or replacement, no further damage is discovered, and the insurance policy has served its purposes of easing the burden of financial loss and providing peace of mind for the insured. In some cases, however, after the time when initial payment is made on the claim, the insured discovers damage that was not apparent earlier, the extent of damage is greater than previously understood, or the amount paid is insufficient to effect repair or replacement. Then the insured may go back to the company and ask for a further amount due under the policy. The company may recognize the validity of its further obligation and pay an additional amount, or it may refuse and, in instances in which it has received a release along with its payment, proffer the release as a bar to the further claim.

It is difficult to document when a release is demanded as a condition of payment of claim and when payment is made without a release. Certainly not all companies demand releases on payment of every claim. Anecdotally, practitioners report that requiring releases has become more common and that they tend to be used more often by some companies than others, in larger claims, and following catastrophes. It is clear that they are used in some large claims, and when they are used, they are sweeping. The language can be simple, framed as a receipt with broad language of release:

Received from Hartford Ins. Co. the sum of \$763,066.67 in full payment, release and discharge of all claims or demands against the said Company, arising from or connected with any loss or damage on or to Building & Loss of Rents at 5601-5611 Georgia Ave., N.W., Washington, D.C., Property Owned by GLM Partnership which loss or damage arose or occurred on or about the 5th day of August 1993.<sup>7</sup>

Or it can be more detailed:

For and in consideration of the total sum of [\$149,203.16 paid to plaintiffs, plaintiffs] forever compromise, release,

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<sup>7</sup> GLM P'ship v. Hartford Cas. Ins. Co., 753 A.2d 995, 998 (D.C. App. 2000).

acquit, and discharge General Star Indemnity Company . . . from any and all claims [plaintiffs] ha[ve] or may have against the Released Parties under General Star Indemnity Company Policy Number IAG360043 . . . whether for building or contents loss or damage, or any other insured and covered loss and damages . . . and any and all other claims and damages of whatsoever kind or nature without limitation whatsoever arising out of the application for insurance, the binding of insurance, the issuance of a policy of insurance, the policy of insurance itself, or out of the hail storm and resulting loss and damage to the aforesaid insured premises and property located thereon, which occurred on or about January 23, 2000 (“the Incident”), as well as of and from any and all claims arising out of the claim itself . . . and, indeed, any and all other claims resulting from, related to, or arising out of or arising from said hail storm whether known or unknown, and whether they have occurred or may occur or become manifest at some future date, without any limitation whatsoever.<sup>8</sup>

The release may be general, as above, or it may specifically address the possibility of undiscovered losses:

[T]he undersigned hereto understand and acknowledge that they may discover facts different from, or in addition to, those which they now know or believe to be true with respect to the subject matters encompassed by this Release, and agree that this Release shall be and remain effective in all respects notwithstanding any subsequent discovery of different and/or additional facts.<sup>9</sup>

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<sup>8</sup> Tulane Prop., Ltd. v. Gen. Star Indem. Co., No. Civ. A. 02-2020, 2003 WL 1824705 (E.D. La. 2003).

<sup>9</sup> Bonita Villas Condo. Ass’n, Inc. v. Empire Indem. Ins. Co., No. 09-21887-CIV, 2010 WL 2541763, at \*1 (S.D. Fla. June 23, 2010). California law expressly authorizes the waiver of future claims in a release. CAL. CODE REGS. tit. 10, § 2695.4(e)(2) (2013). Following Hurricane Andrew, the Florida insurance department “request[ed] that insurers limit the use of general releases to those settlements for which they are appropriate, and insert in said releases language to

Whether the language of the release is general or specific, concise or florid, the fundamental question faced by policyholders and insurers when the subsequent claim arises is whether the release is enforceable. The determination of enforceability rests not on the language of the release but on the law as applied to the context in which the release is executed.

## II. THE PRE-EXISTING DUTY RULE

The fundamental principle governing the enforceability of a release is an ordinary rule of contract law—the pre-existing duty rule. The pre-existing duty rule states, “[p]erformance of a legal duty owed to a promisor which is neither doubtful nor the subject of honest dispute is not consideration.”<sup>10</sup> Under the rule, a release is effective if the releasing party (here, the policyholder) agrees to accept a payment in full satisfaction of its claim and therefore to release the released party (the insurance company) from any further obligation to pay; the consideration for that promise is the company’s payment and its own agreement not to assert that it has an obligation to pay less than the agreed amount.

A different doctrinal approach is to treat the execution and performance of the release as an accord and satisfaction. A release satisfies an existing contractual obligation. An accord and satisfaction, by contrast, substitutes a new obligation for the existing obligation under the original contract; the promise to pay is the accord and the payment itself is the satisfaction.<sup>11</sup> The law on the enforceability of an accord and satisfaction is the same as the consideration analysis. The difference in treatment is only relevant where the parties arguably have agreed to a compromise payment but the compromise has not actually been paid, and that situation rarely arises.<sup>12</sup>

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the effect that the release shall not constitute a final waiver of claims which are reasonably unforeseen on the date of the release.” Fla. Information Bulletin 93-005, 1993 WL 13545478 (Mar. 24, 1993).

<sup>10</sup> RESTATEMENT (SECOND) OF CONTRACTS: PERFORMANCE OF LEGAL DUTY § 73 (1981). *See also* 66 AM. JUR. 2D *Release* § 11 (2013); 46A C.J.S. *Insurance* § 1881 (2013). For examples of the rule’s use in insurance cases, see, for example, *Keller v. State Farm Ins. Co.*, 536 N.E.2d 194, 198 (Ill. App. 1989) (property insurance settlement) and *Hoffman v. Geico Ins. Co.*, 347 Fed. Appx. 295, 296-97 (9th Cir. 2009) (underinsured motorist insurance).

<sup>11</sup> *See* E. ALLAN FARNSWORTH, *CONTRACTS* § 4.24 (4th ed. 2004).

<sup>12</sup> Different still are the cases in which the insured executes a release and subsequently sues the insurer for fraud in connection with the claim payment.

Accordingly, the policyholder's promise to release the company from any further obligation is not supported by consideration if it is only given in return for the company paying something that it already owes under the policy. This result is an application of the oldest instance of the pre-existing duty rule, first announced by Lord Coke in *Pinnel's Case*<sup>13</sup> in 1602 and enshrined in the doctrine of consideration in 1884 by the House of Lords in *Foakes v. Beer*.<sup>14</sup>

Under the pre-existing duty rule, a release is enforceable only if two conditions are met: First, the company's promise to pay and subsequent payment is not the performance of a duty it already owes under the policy. Second, the company's obligation to pay the amount promised is doubtful or the subject of an honest dispute (i.e., if it is a good faith dispute). Conversely, the release lacks consideration and is unenforceable if the company's promise to pay and subsequent payment is only the performance of a duty it already owed under the policy, or if the company's obligation to pay the amount promised is neither doubtful nor the subject of an honest dispute (i.e., if it is not a good faith dispute).

Many early cases applied the doctrine to cases involving life insurance policies, dealt with under doctrines of release, accord and satisfaction, or surrender and rescission.<sup>15</sup> Results variously favored insurers and policyholders, but courts consistently adhered to the requirement that there be a genuine dispute to make a release enforceable. In *The Praetorians v. Taunton*, for example, the Florida Supreme Court applied the pre-existing duty rule to render ineffective a release where the life insurance company had paid the beneficiary less than the value of the policy.<sup>16</sup> Where "the amount due under the terms of the policy has been paid and a receipt delivered and received acknowledging receipt in full and release of the balance due," the release was enforceable only if there was a

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Some courts require rescission of the release and return of the payment prior to the bringing or the successful conclusion of the fraud action. See *Vill. Northridge Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 237 P.3d 598 (Cal. 2010).

<sup>13</sup> *Pinnel's Case*, (1602) 77 Eng. Rep. 237; 5 Co. Rep. 117a ("Payment of a less sum on the day in satisfaction of a greater, cannot be any satisfaction for the whole.")

<sup>14</sup> *Foakes v. Beer*, [1884] 9 H.L. 605 (Eng.).

<sup>15</sup> See Note, *Role of the Check in Accord and Satisfaction: Weapon of the Overreaching Debtor*, 97 U. PA. L. REV. 99 (1948).

<sup>16</sup> *The Praetorians v. Taunton*, 160 So. 676, 676-677 (Fla. 1935).

dispute, as where there was a “valid foundation” or “bona fide cause” for the insurer’s denial of liability “in good faith.”<sup>17</sup>

Even where courts focused in a relatively formal manner on the presence of an agreement to release claims, a dispute was required. In *Lehaney v. New York Life Insurance Co.*, for example, the insurer disputed whether the insured had died from an accident, which would have entitled the beneficiary to double indemnity, or partly from illness, in which case only the face amount of the policy would be due.<sup>18</sup> The Michigan Supreme Court focused on the beneficiary’s endorsement of checks that stated “in full settlement of all claims” as resolving the issue, although it noted that that result would follow only if there was a bona fide dispute resulting in an unliquidated claim.<sup>19</sup>

#### A. THE DUTY OWED

The first step in determining the enforceability of a release is to determine what duty the company owes under the policy, because performance of a duty owed fails to provide consideration for a release. In many respects this issue is tied into the second—whether the claim is doubtful or the subject of an honest dispute. But there is the independent issue of the company’s obligation to pay even if it does not receive a release from the policyholder.

An insurance company’s basic obligation is to pay a claim within the terms of the policy. A company could expressly condition its obligation to pay on receipt of a release from the insured, but policies typically do not do so. The standard homeowners’ policies, for example, in their statement of “Conditions,” includes duties of the policyholder such as giving written notice of an occurrence and filing proof of loss, but they do not require the execution of a release as a condition of payment.<sup>20</sup>

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<sup>17</sup> *Id.*

<sup>18</sup> *Lehaney v. New York Life Ins. Co.*, 11 N.W.2d 830 (Mich. 1943). *See also* *Woodbery v. New York Life Ins. Co.*, 227 N.Y.S. 699 (App. Div. 1928).

<sup>19</sup> *Lehaney*, 11 N.W.2d at 832. *See also* *Hallmark v. United Fid. Life Ins. Co.*, 286 S.W.2d 133 (Tex. 1956) (reviewing authorities).

<sup>20</sup> *E.g.*, INS. SERV. OFFICE, HOMEOWNERS 3 – SPECIAL FORM 20-21 (1999), available at [http://doi.nv.gov/scs/HomeownersPolicyForms/HartfordForms/Hartford\\_HO\\_00\\_03\\_10\\_00.pdf](http://doi.nv.gov/scs/HomeownersPolicyForms/HartfordForms/Hartford_HO_00_03_10_00.pdf); INS. SERV. OFFICE, HOMEOWNERS 5 – COMPREHENSIVE FORM 21 (1999), available at [http://doi.nv.gov/scs/HomeownersPolicyForms/CSAAForms/AAA\\_HO\\_00\\_05\\_10\\_00.pdf](http://doi.nv.gov/scs/HomeownersPolicyForms/CSAAForms/AAA_HO_00_05_10_00.pdf).

That a policy's express terms do not condition the company's duty to pay on the execution of a release also prevents the interpretation of the policy to imply such a condition. The policy expressly states that the policyholder must take several defined steps in pursuing a claim, such as giving notice of an occurrence, filing a proof of loss and, in the event of dispute over the value of a loss, submitting to appraisal. A fundamental maxim of interpretation is *expressio unius est exclusio alterius*—"the expression of one is the exclusion of others." The specification of certain requirements in the policy drafted by the company excludes by implication any other requirements.

The law of tender provides a useful analogy. A tender is an unconditional act made to satisfy an obligation or a condition, distinguished from a proposal, which is a conditional offer. The tenderer is under an obligation to render performance without condition; for example, if a tender of payment is accompanied by a demand for a release or even for a receipt, it is ineffective.<sup>21</sup> The Nebraska Supreme Court applied the analogy to an insurance case, stating,

As there is no affirmative provision therein which expressly or by necessary implication requires the execution of a receipt in full by the assured on payment of a loss under the terms of the policy, no such requirement may be lawfully exacted. The demand for a "receipt in full" relied upon in the instant case was wholly unsupported by the agreement or by authority of law.<sup>22</sup>

This understanding of the company's duty to fully pay a claim demonstrates the error made by a few courts in regarding the payment as a choice among alternatives that satisfies the requirement of consideration. In *GLM Partnership v. Hartford Casualty Insurance Co.*, for example, the court found consideration for a release because the policy gave the insurer the option in the event of loss to either (1) Pay the value of lost or damaged property; (2) Pay the cost of repairing or replacing the lost or damaged property; (3) Take all or any part of the property at an agreed or appraised value; or (4) Repair, rebuild or replace the property with other property of like kind and quality.<sup>23</sup>

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<sup>21</sup> 86 C.J.S. *Tender* § 26 (2013).

<sup>22</sup> *Jensen v. Lincoln Hail Ins. Co.*, 249 N.W. 94, 98 (Neb. 1933).

<sup>23</sup> 753 A.2d 995, 1000 (D.C. Cir. 2000) (citation omitted).

Hartford's choice to pay the claim under option (1) and to forgo the other means of satisfying its obligation was held to provide consideration for the policyholder's promise to release further claims. The court cited in support the revision of *Corbin on Contracts*, which states the rule about choosing among alternative performances as consideration.<sup>24</sup> But the finding of consideration and the citation are inapt. Choosing among alternative performances provides consideration only where the performance rendered fully satisfies the duty chosen. The treatise offers the example of a contract under which A is bound to deliver either a specified car or truck to B; the delivery of the car instead of the truck is consideration for B's promise to pay additional compensation. If A delivers a car that does not conform to the contract, however, its choice to forego delivering the truck is not consideration. Similarly, an insurance company's choice to pay rather than to actually repair is consideration only if the payment constitutes all that actually is due under the policy.

The insurance company also is obligated to pay without demanding a release because of its duty to perform under the policy in good faith. It is axiomatic that there is a duty of good faith implied in every contract including, of course, insurance contracts.<sup>25</sup> In most jurisdictions

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<sup>24</sup> *Id.* (citing 2 JOSEPH PERILLO & HELEN BENDER, CORBIN ON CONTRACTS § 7.12 (rev. ed. 1995)) ("If one has an option between two performances, the giving up of this option, or the exercise of it in one way rather than the other, is consideration for a return promise given in exchange. If one has the privilege of performing in one way rather than another . . . the forbearance to exercise the privilege . . . can be consideration.")

<sup>25</sup> An early case is *Brassil v. Maryland Casualty Co.*, 104 N.E. 622 (N.Y. 1914); leading third-party and first-party cases declaring the principle are *Gruenberg v. Aetna Insurance Co.*, 510 P.2d 1032, 1038 (Cal. 1973), and *Anderson v. Continental Insurance Co.*, 271 N.W.2d 368, 375 (Wis. 1978). Statutory statements of the obligation include COLO. REV. STAT. § 10-3-1113 (2006) ("In any civil action for damages founded upon contract, or tort, or both against an insurance company, the trier of fact may be instructed that the insurer owes its insured the duty of good faith and fair dealing, which duty is breached if the insurer delays or denies payment without a reasonable basis for its delay or denial."); LA. REV. STAT. ANN. § 22:1220 (A) (2007) ("An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing."); WASH. REV. CODE ANN. § 48.01.030 (West 2012) ("The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers,

there is a cause of action for bad faith breach of an insurance contract, and the cause of action may lie in contract or tort or as a statutory remedy. But that cause of action is only a particular product of the general duty of good faith. The general duty is broader in scope although it provides narrower remedies.<sup>26</sup> The obligation of good faith both gives content to the express terms of the contract and supplies terms omitted from the contract.

The most egregious violation of the obligation of good faith is opportunistic behavior.<sup>27</sup>

Opportunism is typically defined as taking selfish advantage of circumstances without regard for principle or prior commitment, such as the commitment made by contract.<sup>28</sup> In entering into a contract, a party limits its future freedom of action in exchange for the benefits it receives under the contract. A deliberate attempt to retain those benefits while avoiding the limits on its own freedom violates the essential nature of the contract.<sup>29</sup> One device for operationalizing this approach is the hypothetical contract; the good faith obligation is “a stab at approximating the terms the parties would have negotiated had they foreseen the circumstances that have given rise to their dispute.”<sup>30</sup>

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and their representatives rests the duty of preserving inviolate the integrity of insurance.”).

<sup>26</sup> The damages available for breach of the good faith obligation are ordinary contract damages and therefore do not include such items as emotional distress, attorneys’ fees, and punitive damages, and, for insurance contracts, may not even include consequential damages. In the release cases, the typical remedy will be the amount to which the policyholder is entitled under the policy, which constitutes the general expectation damages. The difference in remedy is both a disadvantage and an advantage to the policyholder; it is a disadvantage because the potential recovery is less, but it is an advantage because the cause of action can be brought without regard to the procedural and substantive restrictions on the bad faith cause of action. See Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL PRACTICE & INS. L.J. 693 (2012).

<sup>27</sup> See *Market St. Assocs. v. Frey*, 941 F.2d 588, 595 (7th Cir. 1991) (Posner, J.) (“The office of the doctrine of good faith is to forbid the kinds of opportunistic behavior that a mutually dependent, cooperative relationship might enable in the absence of rule.”).

<sup>28</sup> See Oliver E. Williamson, *Opportunism and its Critics*, 14 MANAGERIAL & DECISION ECON. 97 (1993).

<sup>29</sup> Steven J. Burton, *Breach of Contract and the Common Law Duty to Perform in Good Faith*, 94 HARV. L. REV. 369, 373-78 (1980).

<sup>30</sup> *Mkt. St. Assoc.*, 941 F.2d at 595.



Therefore, the use of a release most clearly violates the duty of good faith when it arises from a deliberate attempt to avoid the company's obligation to pay what it owes. At the moment it sold the policy, the company defined the extent of its obligation by the terms of the policy; it is a violation of good faith to attempt to recapture the opportunity to pay less than it owes by demanding and enforcing a release. The parties surely would not have agreed that the company could use the release in such a way to avoid its obligations. If the company demands or enforces a release with the intent of limiting its obligation to a policyholder, either in an individual case or as part of a general scheme, it is not performing in good faith.

More broadly, an insurer's use of a release violates the duty of good faith if it is not in accord with the reasonable expectations of the policyholder. As the Restatement (Second) of Contracts states in an approach to good faith that has been widely adopted, "Good faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party."<sup>31</sup>

The most fundamental expectation of a policyholder is that if a loss occurs, the insurance company will pay what it owes under the policy, no more but no less.<sup>32</sup> Companies present themselves on this basis; among the iconic slogans of American advertising are expressions of this expectation—Allstate's "You're in good hands with Allstate" and the image of cradling hands, State Farm's "Like a good neighbor, State Farm is there," and Nationwide's promise, represented by a security blanket, that "Nationwide is on your side." Therefore, as courts have recognized, in acting on a claim the company has an "almost adjudicatory responsibility. The insurer evaluates the claim, determines whether it falls within the coverage provided, assesses its monetary value, decides on its validity and passes on payment."<sup>33</sup>

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<sup>31</sup> RESTATEMENT (SECOND) OF CONTRACTS § 205 cmt. a (2012).

<sup>32</sup> "Insureds buy financial protection and peace of mind against fortuitous losses. They pay the requisite premiums and put their faith and trust in their insurers to pay policy benefits promptly and fairly when the insured event occurs. Good faith and fair dealing is their expectation. It is the very essence of the insurer-insured relationship." *Campbell v. State Farm Mut. Auto. Ins. Co.*, 98 P.3d 409, 415 (Utah 2004) (quoting *ERIC MILLS HOLMES*, 2-8 *HOLMES' APPLEMAN ON INSURANCE* 2D § 8.7 (2d ed. 1996)).

<sup>33</sup> *Rawlings v. Apodaca*, 726 P. 2d 565, 570 (Ariz. 1986).

The use of a release to bar a policyholder from recovering all that it is owed under the policy violates the policyholder's reasonable expectations. If a company evaluates a claim and demands a release as a condition of its payment and the policyholder later discovers that the payment was not for the full value to which it is entitled under the policy, either through error by the company or worse, the company fails to act in good faith if it uses the release to prevent paying what it owes.

#### B. THE REQUIREMENT OF A DISPUTE

The second step in determining the enforceability of a release under the pre-existing duty rule is to determine whether the release was the product of an honest, good faith dispute. The pre-existing duty rule does not bar the enforcement of a release that is the product of the settlement in good faith of a genuine dispute.<sup>34</sup> Where the parties settle an honest, good faith dispute, each party gives up the valuable right to assert its full claim, so their subsequent performances do not constitute the performance of pre-existing duties. However, this exception only applies where there is a settlement of a genuine dispute or a doubtful claim, or where the surrendering party (here, the insurance company) has a genuine, good faith belief that the claim is doubtful, or both.<sup>35</sup>

The authorities differ on the precise statement of the requirements of honesty and good faith, but the core concept is that the dispute be genuine, so that the insurer is actually giving up something of value—its ability to assert a smaller obligation owed to the insured—in return for the release. *Couch on Insurance* lists several of the common formulations:

- \* A dispute in good faith after a reasonable investigation.
- \* An honest difference between the parties.
- \* An honest doubt between the parties as to the amount due on a policy, whereupon the beneficiary accepts in full satisfaction the amount which the insurer concedes to be due.

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<sup>34</sup> *Vasconcellos v. Arbella Mut. Ins. Co.*, 853 N.E.2d 571, 575 (Mass. App. Ct. 2006).

<sup>35</sup> See RESTATEMENT (SECOND) OF CONTRACTS § 73 cmt. b, § 74(1) (1981); 1 C.J.S. *Accord and Satisfaction* § 46 (2013); FARNSWORTH, *supra* note 11, §4.23; 15 LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* §§ 215:8, :29, :31, :34, :35, 216:22 (3d ed. 2012).

\* A doubtful bona fide claim which is the subject of a bona fide dispute, and concerning which the parties are on equal footing as to knowledge or want of knowledge of the facts.<sup>36</sup>

All of these situations are contrasted with a case in which the dispute is “raised by the insurer in bad faith and without any reasonable ground therefor in law or fact . . . [f]or example, where the position of the insurer is attained only by asserting a legal conclusion which is manifestly wrong.”<sup>37</sup>

The key to determining the application of the pre-existing duty rule and so the enforceability of a release in a particular case is to assess whether or not the release is the product of the resolution of a genuine, good faith dispute. This issue in turn depends on an understanding of the nature of property loss adjusting.

Courts have sometimes characterized the insurance relation as a special relationship of a fiduciary or quasi-fiduciary nature.<sup>38</sup> The insurance relationship is not truly fiduciary, but these characterizations emphasize that adjusting is not an adversarial relationship, but one in which the insurer must reasonably take account of the insured’s interests. For example, the company must be forthcoming with information and assist the insured in processing the claim,<sup>39</sup> advise the insured of the coverage available and the procedure needed to invoke that coverage,<sup>40</sup> and assist the insured in complying with policy conditions and the insurer’s requirements.<sup>41</sup> The company has a duty to investigate a claim adequately and objectively,<sup>42</sup> including to seek evidence that potentially supports a

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<sup>36</sup> 15 RUSS & SEGALLA, *supra* note 35, § 215:34; *see also* §§ 215:35, 215:8, 216:21.

<sup>37</sup> *Id.* § 215:34.

<sup>38</sup> *Id.* § 198:7.

<sup>39</sup> *Bowler v. Fid. & Cas. Co. of N.Y.*, 250 A.2d 580, 588 (N.J. 1969).

<sup>40</sup> *See, e.g.*, 10 CAL. CODE REGS. tit. 10, § 2695.4(a) (2012) (“Every insurer shall disclose to a first party claimant all benefits, coverages, time limits or other provisions that may apply to the claim.”); IOWA ADMIN. CODE r. 191-15.41(507B) (2012).

<sup>41</sup> *See, e.g.*, N.J. ADMIN. CODE § 11:2-17.6 (2012).

<sup>42</sup> *State Farm Fire & Cas. Co. v. Simmons*, 963 S.W.2d 42, 45 (Tex. 1998) (investigation must be objective and not “outcome-oriented”); *Indus. Indem. Co. of the Nw., Inc. v. Kallevig*, 792 P.2d 520, 526 (Wash. 1990) (“An insurer does not have a reasonable basis for denying coverage and, therefore, acts without

claim, not just evidence that favors a denial,<sup>43</sup> and to investigate bases for coverage even beyond those advanced by the insured.<sup>44</sup>

Given this relationship, the typical case of loss adjusting is a process through which the policyholder and the adjuster arrive at a joint conclusion about the proper payment due under the policy; it is not a bargained settlement between parties who are disputing the amount owed. The steps in the process are the policyholder's reporting of a loss, the investigation of the facts and the coverage, and the verification of the extent of loss.<sup>45</sup> Investigating the facts and verifying the loss in turn require determining the scope of damage and pricing the costs of repair.<sup>46</sup> The complexity of this process varies with the extent and complexity of the loss, and the more complex, the more likely that the parties may not agree on the applicable coverages, the scope of damage, or the cost of repair. As classic texts used to train claims personnel state, "The value of most insurance claims is uncertain or must be determined with an element of judgment."<sup>47</sup> "Estimating is not an exact science, and legitimate differences are common."<sup>48</sup> "[D]ifferences may arise from consciously stated positions, but they are more likely to result from unspoken assumptions and misunderstandings."<sup>49</sup> "A difference need not be a disagreement,

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reasonable justification when it denies coverage based upon suspicion and conjecture.").

<sup>43</sup> See *Bernstein v. Travelers Ins. Co.*, 447 F. Supp. 2d 1100, 1112 (N.D. Cal. 2006) ("As these articulations of a carrier's duty indicate, a carrier can be found liable on a bad faith theory for conducting an investigation that is unjustifiably superficial or perfunctory *or that looks only in one self-serving direction* for evidence about the source, nature, or extent of the claimed losses." (emphasis in original)); 15 RUSS & SEGALLA, *supra* note 35, § 207:25 ("Implicit in the duty to investigate is the requirement that the investigation be adequate and fair. Adequacy and fairness means that the insurer has a duty to diligently search for evidence which supports insured's claim and not merely seek evidence upholding its own interests."); DORIS HOOPES, *THE CLAIMS ENVIRONMENT* 10.7 (2000) ("Claims representatives should investigate in an unbiased way, pursuing all relevant evidence, especially that which establishes the legitimacy of a claim.").

<sup>44</sup> *Jordan v. Allstate Ins. Co.*, 56 Cal. Rptr. 3d 312, 319 (Ct. App. 2007).

<sup>45</sup> 1 PROPERTY LOSS ADJUSTING 209 (James J. Markham ed., 2d ed. 1995).

<sup>46</sup> 2 PROPERTY LOSS ADJUSTING 1 (James J. Markham ed., 2d ed. 1995).

<sup>47</sup> JAMES J. MARKHAM ET AL., *THE CLAIMS ENVIRONMENT* 176 (1st ed. 1993).

<sup>48</sup> *Id.* at 176.

<sup>49</sup> *Id.* at 176.

although it often is. A difference exists whenever there is a lack of agreement between the parties.”<sup>50</sup>

Differences that arise during the course of adjusting ordinarily are resolved by a process of sharing information and educating each other about the scope of damage or the cost of repair. They also may be resolved by negotiation between the policyholder and the adjuster, but negotiation in itself does not indicate the presence of a dispute that must be compromised. Instead, negotiation is part of the process of give-and-take that occurs as the parties exchange information, make arguments, and concede points to resolve different understanding of the situation. “Negotiation need not imply an adversarial transaction; it can be cooperative and informative.”<sup>51</sup> Therefore, in the typical case, at the conclusion of the process of loss adjusting there is no actual dispute, even if a release accompanies the claim payment, so the company is not giving up a right to assert a lower value of a claim and its payment does not provide consideration for the policyholder’s release.

Payment in the absence of a genuine dispute does not provide consideration for a release, and this result is particularly clear in two types of cases. One instance is where the insurer makes a partial payment admittedly due under the policy; under the basic application of the pre-existing duty rule that payment of a lesser sum cannot be satisfaction for the whole, the partial payment is not consideration for release of any further claim.<sup>52</sup> Another instance arises under valued policy laws where a settlement for less than the face value of the policy is not enforceable; here the valued policy law makes the entire face value due, so payment of only a part lacks consideration and violates the public policy underlying the valued policy law.<sup>53</sup>

Sometimes, of course, the differences that arise in the loss adjustment process cannot be resolved, the parties deadlock, and the deadlock is resolved by the policyholder accepting a smaller payment than it believes it is entitled to in exchange for the insurer making a larger

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<sup>50</sup> *Id.* at 175.

<sup>51</sup> *Id.* at 177.

<sup>52</sup> *Hallmark v. United Fid. Life Ins. Co.*, 286 S.W.2d 133, 135 (Tex. 1956); *Am. Nat’l Ins. Co. v. Walker*, 81 S.W.2d 1061 (Tex. Civ. App. 1935); *Scott v. Missouri Ins. Co.*, 246 S.W.2d 349, 353 (Mo. Ct. App. 1952).

<sup>53</sup> *E.g.*, *Britton v. Farmers Ins. Group*, 721 P.2d 303, 307 (Mont. 1985); *Gimbels Midwest, Inc. v. N.W. Nat’l Ins. Co. of Milwaukee*, 240 N.W.2d 140 (Wis. 1976).

payment than it believes it owes.<sup>54</sup> It is only in those cases in which the pre-existing duty rule does not apply and a release demanded by the insurer is enforceable to bar a subsequent claim by the insured.

### III. EVALUATING THE APPLICATION OF THE PRE-EXISTING DUTY RULE

The pre-existing duty rule has come in for criticism, and deservedly so. As the Restatement comments point out, the rule “has been much criticized as resting on scholastic logic.”<sup>55</sup> The rule has been rejected in some jurisdictions, either by judicial decision or statute<sup>56</sup> and the Uniform Commercial Code abandons it for sale of goods cases.<sup>57</sup> Nevertheless, the modern understanding of the rule and the exceptions to it actually support the application of the rule to prevent the enforcement of an insurance release that is the product of the ordinary loss adjusting process.

#### A. PURPOSES OF THE RULE

“The fundamental goal of contract modification law is to promote enforcement of freely-made alterations of existing contractual arrangements and to deny enforcement of coerced modifications.”<sup>58</sup> In carrying out this goal, the modern rationale of the pre-existing duty rule is to serve a policing function. The Farnsworth treatise, for example, discusses the rule, including its application to claims settlements, under the topic “Policing of Modification and Discharge.” The rule and its exceptions distinguish between cases in which the parties have made “an equitable adjustment” in their relationship and those in which they have not.<sup>59</sup>

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<sup>54</sup> *E.g.*, *Jones v. Admiral Ins. Co.*, 395 S.E.2d 234 (Ga. App. 1990) (insurer paid maximum despite skepticism about amount of loss).

<sup>55</sup> RESTATEMENT (SECOND) OF CONTRACTS § 73 cmt. c. *See also* *Frye v. Hubbell*, 68 A. 325, 332 (1907) (“the absurdity of the results of the rule . . . has been commented upon in case after case, but persistence in error . . . still calls that right which is recognized to be wrong.”)

<sup>56</sup> *See* FARNSWORTH, *supra* note 11, § 4.25.

<sup>57</sup> *See* U.C.C. § 2-209.

<sup>58</sup> Robert A. Hillman, *Contract Modification under the Restatement (Second) of Contracts*, 67 CORNELL L. REV. 680, 681 (1982).

<sup>59</sup> RESTATEMENT (SECOND) OF CONTRACTS § 73 cmt. c. (1981).

Parties to a contract may agree to modify their contract for legitimate commercial reasons, and the modern exceptions to the pre-existing duty rule make such promises enforceable. One example is unanticipated circumstances arising during the course of performance that would render one party's performance unfairly burdensome. If a builder's cost of performance increases dramatically because of a subsurface condition of which the builder did not know or have reason to know at the time of contracting, the owner's promise to pay the additional cost is not held unenforceable for lack of consideration.<sup>60</sup> The Uniform Commercial Code has abrogated the rule entirely in sales cases; § 2-209 provides that a modification needs no consideration to be binding. A buyer may, for example, agree to accept goods of a lesser quantity or quality than was contracted for, and the fact that the seller is already under a duty to perform a greater obligation is no bar to enforcement of the buyer's promise; the law recognizes the commercial reality that a contracting party may value a bird in the hand more than two in the bush. However, the power to create an enforceable modification under the Code is not unlimited; the modification is policed by the requirement of good faith, which requires that the new agreement be honest and in accord with "reasonable commercial standards of fair dealing."<sup>61</sup>

On the other hand, modifications or (as in the insurance release cases) discharges that are not commercially reasonable attempts to adjust the relationship or to make the best of a bad situation do not deserve to be enforced. In these cases the pre-existing duty rule serves an appropriate policing function in two ways.

First, it embodies the essential definition of contract law as the body of law that enforces exchanges.<sup>62</sup> Exchange is the foundation of the doctrine of consideration, which makes enforceable only those promises that are bargained for.<sup>63</sup> By definition, an exchange is two-sided, and the pre-existing duty rule enforces that definition. Where nothing in legal contemplation is exchanged on one side—where a party such as an insurance company does no more than make a payment it is otherwise obligated to make—there is no exchange and therefore no enforceable promise.

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<sup>60</sup> RESTATEMENT (SECOND) OF CONTRACTS § 89 (1981).

<sup>61</sup> U.C.C. §§ 1-201(b)(20); 2-209 cmt. 2. (1977).

<sup>62</sup> FARNSWORTH, *supra* note 11, § 1.1 at 4.

<sup>63</sup> RESTATEMENT (SECOND) OF CONTRACTS § 71 (1979).

Second, in some cases one party will take advantage of the lack of expertise or leverage of the other party to obtain a modification or discharge that is unfair or disproportionate. Other policing doctrines such as fraud and duress may not provide a remedy because courts understandably do not apply those doctrines expansively. In those cases, the pre-existing duty rule provides a backstop to prevent the enforcement of modifications or discharges that were unfairly obtained, are unreasonable, or lack business efficacy.

#### B. PUBLIC POLICIES

One of the criticisms of the pre-existing duty rule is that it upsets the resolution of disputes parties have achieved themselves and permits litigation that reopens settled claims. This effect is at odds with the strong public policy favoring the settlement of disputes, a policy that grants a presumption of validity to releases.<sup>64</sup> The policy favoring settlement has several roots. From the contract law perspective, it reflects the value of personal autonomy and choice that is a core value of contract law. From the legal system perspective, it permits parties to avoid the costs and uncertainties of litigation and reduces the social expenditure on litigation.

In fact, as properly stated the public policy favoring settlement is entirely consistent with the application of the pre-existing duty rule to insurance releases. The public policy, prosaically stated, is as follows:

The purpose of compromise is to avoid trial of sharply disputed issues and to dispense with wasteful litigation. The settlement of cases serves the dual and valuable purposes of reducing the strain on scarce judicial resources and preventing the parties from incurring significant litigation costs.

The law and public policy generally supports a presumption in favor of voluntary settlement of litigation, and settlement agreements should therefore be upheld whenever equitable and policy considerations so permit.<sup>65</sup>

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<sup>64</sup> 66 AM. JUR. 2D, *Release* § 2 (2011).

<sup>65</sup> 15A C.J.S. *Compromise & Settlement* § 1 (2013).



A compromise agreement fairly made, based on good consideration, and assented to by both parties, is valid and binding on both.<sup>66</sup>

There are three relevant elements to this policy.

First, it is only implicated if there is a controversy or dispute to be resolved. That requirement parallels the pre-existing duty rule's requirement of a genuine, good faith dispute to render a release enforceable.

Second, it applies only to releases that are "fairly made" and "assented to by both parties." This is a statement about the process of arriving at a settlement, not a substantive review of its fairness. It requires that both parties have reason to know of the nature of the dispute and of the effect of the release.

Both of these elements become problematic when the release is given in the ordinary process of adjusting. In that process the parties arrive at a common understanding of the loss, which is not the same as resolving a dispute, and the policyholder has no reason to understand the situation in any other way.

Third, the policy favoring settlement must be balanced against any conflicting public policy. In the release cases, that policy is the broad public policy underlying the provision and regulation of insurance.

As a risk management tool, the purchase of insurance is a transaction through which the insured trades a small, certain loss (the premium) to protect against a larger, uncertain loss (the risk insured against). For many policyholders, particularly consumers and small businesses, insurance is seen more broadly as a vehicle to secure oneself against financial catastrophe. The Arizona Supreme Court was one among many courts to recognize the dual role of insurance:

In delineating the benefits which flow from an insurance contract relationship we must recognize that in buying insurance an insured usually does not seek to realize a commercial advantage but, instead, seeks protection and security from economic catastrophe. Thus, the insured's object in buying the company's express covenant to pay claims is security from financial loss which he may sustain from claims against him and protection against economic

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<sup>66</sup> 15A C.J.S. *Compromise & Settlement* § 4 (2013).

catastrophe in those situations in which he may be the victim. In both cases, he seeks peace of mind from the fears that accompany such exposure.”<sup>67</sup>

Requiring the insurance company to fully perform its obligations is particularly important because of the lack of an available substitute if the company fails to perform. In a typical contract, if one party does not perform, the other party can procure a substitute performance, sue for any added cost, and, at least in concept, be made whole by the provision of damages. But if a property owner suffers a loss and its insurance company fails to pay the claim in full, there is no adequate substitute, as no company will sell insurance to compensate for a loss that has already occurred.<sup>68</sup>

Therefore, there is a strong public policy favoring the provision of insurance and the payment of claims in full. The policy is embodied throughout insurance law.<sup>69</sup> Interpretation doctrines state that ambiguities in policies should be construed against the insurance company, that grants of coverage should be interpreted broadly and exclusions narrowly, and, in many jurisdictions, the reasonable expectations of policyholders are protected even in the face of contrary policy language.<sup>70</sup> Doctrines of waiver and estoppel lead to payment of claims that would not necessarily

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<sup>67</sup> *Rawlings v. Apodaca*, 726 P.2d 565, 569-71 (Ariz. 1986) (citations omitted); *See also Decker v. Browning-Ferris Indus. of Colo., Inc.*, 931 P.2d 436, 443 (Colo. 1997) (“[A]n insured who enters into a contract of insurance seeks to obtain ‘financial security and protection against calamity.’”) (quoting *Farmers Grp., Inc. v. Trimble*, 691 P.2d 1138, 1141 (Colo. 1984)); *Andrew Jackson Life Ins. Co. v. Williams*, 566 So. 2d 1172, 1179 n.9 (Miss. 1990) (“[A]n insured bargains for more than mere eventual monetary proceeds of a policy; insureds bargain for such intangibles as risk aversion, [and] peace of mind.”) (alteration in original).

<sup>68</sup> *See Foley v. Interactive Data Corp.*, 765 P.2d 373, 396 (Cal. 1988) (“[A] breach in the employment context does not place the employee in the same economic dilemma that an insured faces when an insurer in bad faith refuses to pay a claim or to accept a settlement offer within policy limits. When an insurer takes such actions, the insured cannot turn to the marketplace to find another insurance company willing to pay for the loss already incurred.”).

<sup>69</sup> *See Bob Works, Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case*, 5 CONN. INS. L.J. 505, 574 (1998-89).

<sup>70</sup> *See, e.g., Rodman v. State Farm Mut. Ins. Co.*, 208 N.W.2d 903, 905-08 (Iowa 1973) (explaining the reasonable expectations doctrines in insurance law).

be covered otherwise.<sup>71</sup> Statutes impose requirements of intent to deceive or materiality on misrepresentations by insureds before the insurer can use the misrepresentation as a basis for avoiding the claim.<sup>72</sup> In a variety of cases courts interpret particular policy conditions favorably to coverage, sometimes more favorably than their plain meaning or drafting history might justify.<sup>73</sup> The Model Unfair Claims Settlement Practices Act promulgated by the National Association of Insurance Commissioners and adopted in most states requires insurers to attempt “in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear” and not “for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.”<sup>74</sup>

In ordinary property loss adjusting cases, the public policy favoring settlement is not relevant. Only where a release follows the resolution of a genuine dispute in good faith is the policy properly applied and not inconsistent with the public policy favoring insurance coverage. Moreover, the principal reason courts refuse to enforce a contract on the grounds of public policy is to discourage undesirable conduct. Enforcing a release would actually encourage improper claim practices. The release operates to limit a company’s ultimate liability in cases in which it underpays claims due to simple error, negligence, failure to train or employ qualified personnel, bias, or even a systematic strategy of denying valid claims in whole or part. If releases could be demanded as a condition of the payment of claims and were enforceable, the economic benefits of requiring releases would become apparent. A company then would be encouraged to require a release as a condition of payment of a claim in every case. And given market pressures to limit costs, all companies would have an incentive to act in the same way. These effects would undermine

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<sup>71</sup> See, e.g., *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 682 P.2d 388, 395 (Ariz. 1984) (en banc); *Jenkins v. Indem. Ins. Co. of N. Am.*, 205 A.2d 780, 783-84 (Conn. 1964).

<sup>72</sup> E.g., IOWA CODE ANN. § 515.101 (West 2001) (effective July 1, 2009); MASS. GEN. LAWS ANN. ch. 175 § 186 (West 2007) (effective Feb. 5, 2009).

<sup>73</sup> See, e.g., *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994) (discussing trigger of coverage in asbestos cases); *Voorhees v. Preferred Mut. Ins. Co.*, 607 A.2d 1255 (N.J. 1992) (dealing with emotional harm as bodily injury); *Ambassador Ins. Co. v. Montes*, 388 A.2d 603 (N.J. 1978) (dealing with an intentional act in liability policy).

<sup>74</sup> MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4 (NAIC 2007).

the nature of insurance and the requirement of fair claim practices. As a result, there would be more cases in which policyholders did not receive the benefits they had contracted for and to which they were entitled. Therefore, a release that is required as a condition of payment of a claim and that is not the product of settlement of a genuine, good faith dispute, should be held unenforceable as a matter of public policy.

#### IV. CONCLUSION

The essential obligation of an insurance company is to pay what it owes under the policy if its insured suffers a loss. In property loss cases, that obligation is effectuated through a fluid process of adjusting that involves uncertainty, expertise, and judgment. Most of the time, that process results in an agreement on the amount owed. Because the process is uncertain, that amount may turn out to be incorrect, and if it is, the company cannot avoid its essential obligation to the policyholder by claiming that a release signed at the time of payment—a release that it is not entitled to demand under the policy—limits its obligation. A hoary rule of contract law and the public policy that recognizes the value of insurance coalesce to dictate this result.



## MANDATES, MARKETS, AND RISK: AUTO INSURANCE AND THE AFFORDABLE CARE ACT

JENNIFER B. WRIGGINS\*

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*Now that the Affordable Care Act (ACA) individual health insurance mandate has been upheld by the United States Supreme Court, it is an opportune time to examine precedents for the individual mandate that were not considered in the legislative debate or litigation about the ACA's constitutionality, particularly auto insurance mandates. Although opponents' arguments were cast largely as Commerce Clause claims, the arguments have a deeper foundation as claims about liberty and coercion which go far beyond the Commerce Clause. Although auto insurance mandates are obviously different, particularly in that they are state rather than federal, auto insurance mandates can help us understand what Congress was doing, and why, when it enacted the ACA reforms and the individual mandate. Auto insurance mandates are relevant because they are a ubiquitous example of risk-spreading through a combination of private markets and public regulation, which is the same broad approach taken by the ACA individual mandate. This article shows that auto insurance mandates are an important precedent for the ACA individual mandate, and have four significant parallels with the ACA provision. First, both arose from challenging situations where there are compelling reasons for mandates. Second, both types of mandate order that people insure*

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\* Sumner T. Bernstein Professor of Law, University of Maine School of Law. Many thanks to Dean Peter Pitegoff of the University of Maine School of Law for funding for this project, to Chris Harmon, Maine Law Class of 2014, Kevin Decker, Maine Law Class of 2014, and Kasia Park, Maine Law Class of 2013 for research assistance, to librarians Julie Welch, Maureen Quinlan, Greg Stowe, and Christine Hepler of the Garbrecht Law Library at University of Maine School of Law for marvelous work in tracking down sources, to the Faculties of the University of Maine School of Law and of Brooklyn Law School for useful discussions at faculty workshops, and to Administrative Assistants Megan Eades, Heidi Gage, and Tara Wheeler for their skilled and excellent help. Also thanks to students in my insurance law classes and to Dmitry Bam, Mary L. Bonauto, Malick Ghachem, Chris Harmon, Vaishali Mamgain, Dave Owen, Sarah Schindler, Theda Skocpol, and Laura Underkuffler for helpful conversations. I greatly appreciate comments from Kenneth S. Abraham, Tom Baker, Dmitry Bam, Mary L. Bonauto, Martha Chamallas, Malick Ghachem, Dave Owen, William P. Marshall, Christopher J. Robinette, Sarah Schindler, and an anonymous peer reviewer on various versions of this article.

*themselves against risks they might want to bear themselves. Both types require that risks be transferred and spread, which is an essential aspect of what insurance does. Last, both require people to buy something from a private seller. Both mandates are similar policy responses to important public policy dilemmas involving physical harm or illness and how to finance needed redress or treatment.*

*The article turns to the common rejoinder that auto insurance mandates are fundamentally different because driving is a choice and so regulation is acceptable, in contrast to the ACA mandate which regulates living itself, not an acceptable thing for government to do. This argument is specious for at least three reasons. First, driving is not always a choice. Second, the Supreme Court's decision shows that the ACA mandate actually does create a choice. Third, auto insurance mandates actually are far more coercive than the ACA individual mandate.*

*Finally, the article unearths and highlights pertinent aspects of the history of auto insurance mandates. Opponents fought mandates for six decades using arguments about freedom and American values to oppose them, much as ACA mandate opponents do today. Doubts about and challenges to the constitutionality of mandates were consistently resolved in their favor particularly in light of the public welfare aspects of insurance. "Freedom" arguments have faded over time and auto insurance mandates have proven themselves a workable, widely accepted, very American way of dealing with risk.*

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## I. INTRODUCTION

In *National Federation of Independent Business v. Sebelius*, all of the justices of the United States Supreme Court viewed the Affordable Care Act's (ACA's) individual health insurance mandate as legislation aimed to influence individual conduct.<sup>1</sup> The justices disagreed on the legal implications of that conclusion. Justice Roberts' majority opinion treated the mandate as a constitutionally permissible tax on the decision to not buy health insurance but not as permissible under the commerce power.<sup>2</sup> Justice Ginsburg's opinion would have found the mandate constitutional under

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<sup>1</sup> Nat. Fed'n. of Indep. Bus. (NFIB) v. Sibelius, 132 S. Ct. 2566 (2012).

<sup>2</sup> *Id.* at 2576-601.

either power,<sup>3</sup> and the four dissenting justices would have rejected the mandate's constitutionality.<sup>4</sup> But despite these disagreements, all of the justices seem to agree that the mandate's focus on individual regulation is central to the case. In their opinions and in their questions at oral argument, some of the justices seemed to suggest that by taking this step toward regulating individual behavior, Congress was doing something new, legally questionable and perhaps even dangerous.<sup>5</sup>

The ACA and the mandate are likely to be with us for some time. And there may well be other circumstances in which Congress or state legislatures might consider adopting similar individual mandates. Consequently, now is an opportune time to examine important precedents for the individual mandate that were largely overlooked in the debate about its constitutionality.<sup>6</sup> Of these precedents, none is more important than auto insurance mandates, as this Article shows.

Auto insurance mandates are obviously different in some ways from the health insurance mandate. Importantly, they are creations of state law, and Commerce Clause issues therefore do not arise.<sup>7</sup> Nevertheless, they are still absolutely relevant. Underlying the constitutional challenge was the idea that the ACA's requirement that someone buy health insurance, regardless of the reason for the requirement, was a frightening,

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<sup>3</sup> *Id.* at 2609-42.

<sup>4</sup> *Id.* at 2642-77.

<sup>5</sup> Some of the questions at oral arguments over potential types of mandates, such as being compelled to join an exercise club, Transcript of Oral Argument at 40, *NFIB v. Sibelius*, 132 S. Ct. 2566 (2012) (No. 11-393), to buy broccoli, *id.* at 13, or to buy burial insurance, *id.* at 7, are examples. Justice Alito's questions seemed to indicate deep skepticism about the basic risk-sharing characteristics of insurance and the mandate, *id.* at 7-8. Justice Scalia wrote, "[i]f Congress can reach out and command even those furthest removed from an interstate market to participate in the market, then the Commerce Clause becomes a font of unlimited power." See *NFIB*, 132 S. Ct. at 2646.

<sup>6</sup> Indeed, since the Supreme Court's decision, the issue of auto insurance mandates as precedents has resurfaced, with Representative Michelle Bachmann claiming on CNN that auto insurance mandates are totally different from the ACA's individual mandate. *Piers Morgan Tonight*, Clips From Last Night: Michele Bachmann on Car Insurance Versus Health Insurance, CNN (July 7, 2012), <http://piersmorgan.blogs.cnn.com/2012/07/03/clips-from-last-night-michelle-bachman-on-car-insurance-versus-health-insurance-glenn-frey-on-changes-in-the-music-industry/>.

<sup>7</sup> Justice Roberts stated, "[a]ny police power to regulate individuals as such, as opposed to their activities, remains vested in the States." *NFIB*, 132 S. Ct. at 2591.



unjustifiable, and unprecedented intrusion on personal liberty.<sup>8</sup> Although this argument was not explicitly made, it was an essential backdrop to the litigation in general and to the Commerce Clause argument in particular.<sup>9</sup> This focus of mandate opponents on ideas of liberty and coercion, with a visceral opposition to government mandates, is likely to endure despite the ACA mandate's having been upheld. The vehicle for the liberty and coercion arguments in *Sibelius* was the Commerce Clause, and in the future another constitutional provision may be pressed into service to make similar or even broader arguments.<sup>10</sup> Our experience with auto insurance mandates should help us evaluate whether these arguments have merit.

At a more basic level, understanding the role of individual mandates in automobile insurance can help us understand what Congress

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<sup>8</sup> As Eleventh Circuit Court of Appeals Judge Marcus noted in his dissent in *Florida v. Dept. of Health and Human Serv's.*, "implicit in the plaintiffs' Commerce Clause challenge...is the deeply rooted fear that the federal government is infringing upon the individual's right to be let alone—a fear that is intertwined with a visceral aversion to the government's making us do something we do not want to do." *Florida ex rel. Atty. Gen. v. U.S. Dept. of Health & Human Serv's.*, 648 F.3d 1235 (11th Cir. 2011) *cert. granted*, 132 S. Ct. 603 (2011) *aff'd in part, rev'd in part sub nom. NFIB*, 132 S. Ct. at 2566. *See also*, William P. Marshall, *National Healthcare and American Constitutional Culture*, 35 HARV. J.L. & PUB. POL'Y 1, 144-47 (2012) (noting particularly American distrust of government). Charles Fried blogged shortly after the *Sibelius* decision: "the energy behind the broccoli argument was about personal liberty, and no litigant ventured that the mandate violated the liberty clause of the Fifth Amendment." Charles Fried, *The June Surprises: Balls, Strikes, and the Fog of War*, SCOTUSBLOG (Aug. 2, 2012, 12:19 PM), <http://www.scotusblog.com/2012/08/the-june-surprises-balls-strikes-and-the-fog-of-war/>. For an explanation of the "broccoli argument," *see infra* note 23.

<sup>9</sup> *See supra* note 5. *See also, e.g.*, Fried, *supra* note 8.

<sup>10</sup> Charles Fried wrote in his blog post shortly after the decision: "Of course, the real shadow of impropriety on everyone's mind but studiously omitted from the argument and justifications is the supposed intrusion *on individual liberty* implicated in Congress's scheme: the offense to liberty in requiring someone to enter the market and buy something from a nongovernmental purveyor... But the argument was not made because it would have had to be made under the Liberty Clause of the Fifth Amendment, and this would have carried over to the similar clause in the Fourteenth and therefore rendered any such a scheme enacted by a state, such as Massachusetts, similarly invalid." *See* Fried, *supra* note 8. Massachusetts and New Jersey passed individual health insurance mandates before the ACA was passed. *See* MASS. GEN. LAWS ANN. ch. 111M § 2 (West 2006) and N.J. STAT. ANN. § 26:15-2 (West 2009). The constitutionality of these mandates has not been challenged to date.

was doing, and why, when it enacted the individual mandate. Auto insurance mandates are a ubiquitous example of risk-sharing through a combination of private markets and public regulation, which is the same broad approach taken by the ACA individual mandate.<sup>11</sup> They also are an important example, like the ACA individual mandate, of using private insurance to tackle complex and wide-ranging problems involving illness and injury which have significant public dimensions. While our society uses private insurance to respond to many economic challenges, insurance and insurance principles are often ignored or not understood by the public, whether the subject is health, auto, or other insurance.<sup>12</sup> That common lack of understanding in turn creates fertile grounds for sweeping arguments about individual liberty—arguments that nearly overturned the ACA and that might well gain even greater traction in future debates. It is an ideal time to examine what auto insurance mandates can tell us about the ACA individual insurance mandate and about insurance mandates more generally. These questions are largely unexamined in academic literature and political discourse, perhaps because the ACA's advocates and

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<sup>11</sup> See *infra* Part II.

<sup>12</sup> According to one study by the National Association of Insurance Commissioners (NAIC), nearly 60 percent of Americans feel confident about making insurance decisions concerning auto, home, and life insurance, but after taking a 10 question “insurance IQ test” the majority of responders to the survey received a failing score of 40 percent. *Americans Believe They’re Savvy About Insurance, But NAIC Insurance IQ Tells Different Story*, NAT’L ASS’N OF INS. COMM’RS (Mar. 10, 2009), [http://www.naic.org/Releases/2009\\_docs/insurance\\_iq.htm](http://www.naic.org/Releases/2009_docs/insurance_iq.htm). The NAIC also conducted a survey of 1,000 Americans concerning their awareness of car insurance which revealed that “some of the basics of auto insurance are not well understood, even though it is one of the most commonly purchased types of insurance by people of all ages and demographics.” *New NAIC Insurance IQ Study Reveals Americans Lacking in Confidence, Knowledge of Insurance Choice*, NAT’L ASS’N OF INS. COMM’RS (Apr. 6, 2010), [http://www.naic.org/Releases/2010\\_docs/iiq\\_new.htm](http://www.naic.org/Releases/2010_docs/iiq_new.htm). This same survey also found that “86 percent of respondents said they do not understand all of the terms being used in the current discussion on health care reform.” *Id.* The Arizona Department of Transportation released a report in 2004 regarding trends in insurance coverage which notes that “many people do not understand the difference between liability coverage and uninsured motorist coverage.” Lisa Markkula, *Uninsured and Underinsured Motorists: Trends in Policy and Enforcement*, ARIZ. DEP’T OF TRANSP., (June 2004), [http://www.azdot.gov/tpd/atrc/publications/project\\_reports/pdf/az548.pdf](http://www.azdot.gov/tpd/atrc/publications/project_reports/pdf/az548.pdf).

defenders did not emphasize them,<sup>13</sup> and perhaps because insurance principles are not widely understood.<sup>14</sup> That absence of examination leaves a significant gap in the literature which this Article endeavors to fill.

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<sup>13</sup> Auto insurance mandates were rarely mentioned in the litigation concerning the ACA or in the legislative discussions of it. In its opening brief, the federal government defended the health care individual mandate in part by referring to state auto insurance mandates, but did not develop the argument. It wrote that: “States have mandated insurance when (as here) an individual’s lack of insurance shifts risk to others.” See 1 STEVEN PLITT ET AL., *COUCH ON INSURANCE* 3d § 1:50 (rev. ed. 2009) (discussing mandatory automobile insurance laws). Congress therefore acted well within its constitutional authority by adopting a means of regulation parallel to insurance measures enacted by the states to address comparable risk-shifting.” Brief for Petitioner at 36, *NFIB v. Sebelius* (U.S. Jun. 28, 2012) (No. 11-393). Auto insurance mandates were touched on superficially in the oral argument, Transcript of Oral Argument at 65, *NFIB v. Sibelius*, 132 S. Ct. 2566 (2012) (No. 11-393). Sixth Circuit Judge Sutton noted the “related and familiar mandate of the states-that most adults must purchase car insurance” in his opinion supporting the constitutionality of the individual mandate, but did not explore this point in detail. *Thomas More Law Center v. Obama*, 651 F.3d 529, 565 (6th Cir. 2011).

President Obama mentioned car insurance mandates as precedents but neither he nor other proponents of the mandates made a detailed argument based on these mandates. In remarks to Congress, the President in 2009 described the necessity of everyone participating in a health insurance pool, and explained as follows: “Now, even if we provide these affordable options [like insurance provided through exchanges meant to foster competition] there may be those-especially the young and the healthy-who still want to take the risk and go without coverage...The problem is, such irresponsible behavior costs all the rest of us money. If there are affordable options and people still don’t sign up for health insurance, it means we pay for those people’s expensive emergency room visits.... Unless everybody does their part, many of the insurance reforms we seek-especially requiring insurance companies to cover preexisting conditions-just can’t be achieved. *And that’s why under my plan, individuals will be required to carry basic health insurance-just as most states require you to carry auto insurance.*” President Barack Obama, *Remarks by the President to a Joint Session of Congress on Health Care* (Sept. 9, 2009) [http://www.whitehouse.gov/the\\_press\\_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care](http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care). See generally Erwin Chemerinsky, *Health Reform is Constitutional*, POLITICO (Oct. 22, 2009, 4:59 AM), <http://www.politico.com/news/stories/1009/28620.html> (mentioning auto insurance as a precedent). The idea of a federal individual mandate originated with the Heritage Foundation over twenty years ago. A 1989 Heritage Foundation publication, which endorsed the idea of an individual mandate, cited auto insurance as a precedent, stating that a National Health Plan should: “Mandate all households to obtain adequate insurance. Many [states] require anybody driving a

This Article, in Part I, makes the argument that auto insurance mandates are pertinent precedents and draws four important parallels between auto insurance mandates and the ACA individual mandate. Both were developed to tackle complex, challenging public policy situations involving physical harm or illness and how to pay for needed redress or treatment; they devised similar policy responses to seemingly intractable dilemmas.<sup>15</sup> Both require people to insure themselves against risks they may want to bear themselves.<sup>16</sup> Both require risk-spreading, which is fundamentally what insurance does.<sup>17</sup> Finally, both require people to buy something from a private seller rather than having a government program tackle the problems at which the mandates are aimed; they both embody a public-private policy approach.<sup>18</sup>

Part II discusses the most common rejoinder to the claim that auto insurance mandates are pertinent precedents, which is that auto insurance is irrelevant because driving is a choice while living is not. This Part shows that choice and coercion are much harder to distinguish in this context than opponents contend. Driving is not always a choice,<sup>19</sup> the Supreme Court's decision made clear that the decision whether to purchase insurance for

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car to have liability insurance. But neither the federal government nor any state requires all households to protect themselves from the potentially catastrophic costs of a serious accident or illness. Under the Heritage [Foundation] plan, there would be such a requirement." Stuart M. Butler, *Assuring Affordable Health Care for All Americans*, HERITAGE FOUNDATION LECTURE NO. 218 (Oct. 1, 1989) at 6. Mandate opponents Randy Barnett, Nathaniel Stewart, and Todd Graziano, representing a later and very different Heritage Foundation position, wrote a memorandum in 2009 preemptively deriding the idea of a parallel. Randy Barnett, Nathaniel Stewart, & Todd Graziano, *Why the Personal Mandate to Buy Health Insurance is Unprecedented and Unconstitutional*, LEGAL MEMORANDUM No. 49 (Dec. 9, 2009) (hereinafter Barnett/Heritage Memo). Although the parts of the article dealing with car insurance were inaccurate, there was no systematic response to that part of the memorandum until 2012. See Jennifer Wriggins, *Is the Health Insurance Individual Mandate "Unprecedented?": The Case of Auto Insurance Mandates*, SSRN (Feb. 25, 2012), <http://ssrn.com/abstract=2011025>.

<sup>14</sup> See *supra* note 12.

<sup>15</sup> See *infra* Part I.A.

<sup>16</sup> See *infra* Part I.B.

<sup>17</sup> See *infra* Part I.C.

<sup>18</sup> See *infra* Part I.D.

<sup>19</sup> See *infra* Part II.A.

those subject to the mandate actually is a choice,<sup>20</sup> and auto insurance mandates in fact are more coercive than the ACA mandate.<sup>21</sup>

Finally, the Article in Part III turns to two aspects of the history of auto insurance mandates. One is the complex evolution of mandates, which took place over a six decade period.<sup>22</sup> Now forgotten but relevant today is that opponents of mandates fought against them for decades, using arguments about freedom and American values similar to the ‘broccoli argument’ used today.<sup>23</sup> Yet, in the battle over how to pay for injuries connected with car accidents, governments did not take over the risk and publicly fund car accident costs, but rather left the situation to a regulated market—a market that required individual participation and that broadened coverage through mandates ordering companies to cover high risk individuals. The insurance industry developed insurance products to keep risk privatized and adjusted successfully to the mandates. Not surprisingly, ‘freedom’ arguments lack resonance today in the auto insurance context. Also forgotten but relevant is the legal history of auto insurance mandates and auto insurance regulation.<sup>24</sup> The constitutionality of auto insurance mandates was doubted and challenged all the way to the United States Supreme Court.<sup>25</sup> The Supreme Court and other courts recognized that insurance laws affecting individuals’ and companies’ freedom, such as requiring individuals to buy insurance or companies to cover high risk drivers, were permissible regulation especially in view of the public welfare aspect of insurance. With constitutional doubts laid to rest, the current public-private auto insurance regulation regime, with mandates

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<sup>20</sup> See *infra* Part II.B.

<sup>21</sup> See *infra* Part II.C.

<sup>22</sup> See *infra* Part III.

<sup>23</sup> See *infra* Part III.A. The “broccoli argument” was a slippery-slope argument advanced to support the position that the health insurance mandate in the ACA exceeded Congress’s authority under the Commerce Clause. According to the “broccoli argument,” if Congress has the power to require individuals to purchase health insurance because it improves their health, which in turn affects interstate commerce, then Congress could also require individuals to engage in other health behavior like purchasing broccoli, which seems absurd. See *NFIB v. Sibelius*, 132 S. Ct. 2566, 2588-89 (2012). But see *id.* at 2619 (Ginsburg, J., dissenting in part) (responding to broccoli argument). See also Fried, *supra* note 8 (discussing broccoli argument).

<sup>24</sup> See *infra* Part III.B.

<sup>25</sup> See *Ex parte Poresky*, 54 S. Ct. 3, 4 (1933); *Calif. State Auto. Assoc. Inter-Insurance Bureau v. Maloney*, 341 U.S. 105, 107 (1951), discussed *infra* at Part III.B.

coupled with private competition, has thrived for decades, to the benefit of consumers. This history suggests that the ACA individual mandate may gain more acceptance as the ‘freedom’ arguments lose resonance and the benefits of the ACA become clearer.

This article shows that the ACA mandate is not the anomalous outlier that its opponents claim and that it follows an American tradition of tackling a huge problem by a public-private approach of insurance regulation and mandates. Individual insurance mandates in both the auto and health contexts are a reasonable approach to widespread problems through economic regulation, rather than a frightening infringement on personal freedom.

## II. MAKING THE ARGUMENT: PARALLELS BETWEEN THE ACA AND AUTO INSURANCE INDIVIDUAL MANDATES

This section systematically draws parallels between the characteristics of auto insurance mandates and the ACA’s individual mandate. Obviously, health insurance and auto insurance are very different, and insuring people’s health raises different issues from insuring against losses associated with cars.<sup>26</sup> Public policy debates about the two issues have gone on for decades, although the battle over universal health care has had a higher profile.<sup>27</sup> Auto insurance mandates are not

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<sup>26</sup> See generally ROBERT JERRY & DOUGLAS RICHMOND, UNDERSTANDING INSURANCE LAW § 64[C], at 918 (5th ed. 2012); Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL’Y & L., 287 (1993); Nicholas Bagley & Jill R. Horwitz, *Why It’s Called the Affordable Care Act*, 110 MICH. L. REV. FIRST IMPRESSIONS 1 (2011) (reforms aimed at myriad problems with U.S. health care system); Tom Baker, *Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act*, 159 U. PENN. L. REV. 1577 (describing Affordable Care Act as creating a new social contract). Issues of health care costs and health insurance in the U.S. are tremendously complex. See, e.g., JOSEPH E. STIGLITZ, ECONOMICS OF THE PUBLIC SECTOR 300-30 (3d ed. 2000); Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of ACA*, 36 J. OF CORP. L. (2011); Brief of Amici Curiae Economic Scholars in Support of Petitioners Urging Reversal on the Minimum Coverage Issue, *Health and Human Services v. Florida*, 132 S. Ct. 604 (2011) (No. 11-398) (describing unique features of health care finance and insurance).

<sup>27</sup> See generally Jonathan Simon, *Driving Governmentality: Automobile Accidents, Insurance, and the Challenge to the Social Order in the Inter-War Years: 1919-1941*, 4 CONN. INS. L. J. 525 (1997-1998) (describing history of spread of autos, injuries, and regulatory responses); Bagley & Horwitz, *supra* note 26, at 8 (battle over universal health coverage has lasted almost 100 years); THEDA

monolithic; there are several different types of commonly mandated auto insurance.<sup>28</sup> Yet, both mandates essentially devised the same policy response to a huge public policy problem involving how to pay for treatment or redress for physical illness or harm. The significant similarities between the mandates are outlined next.

A. BOTH TYPES OF MANDATES APPLY TO COMPLEX, CHALLENGING SITUATIONS WHERE THERE ARE STRONG POLICY REASONS FOR MANDATES

1. ACA Individual Mandate

One of the goals of the ACA was to increase health insurance coverage, and the ACA individual mandate is an important means to that goal.<sup>29</sup> At the time the ACA was passed, there was bipartisan consensus that extensive reform of the extremely complex U.S. health insurance system was urgent.<sup>30</sup> The ACA individual mandate was modeled on Massachusetts' individual mandate that passed in 2006, although the ACA is a far broader and more complex law than the Massachusetts reforms.<sup>31</sup>

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SKOCPOL, PROTECTING SOLDIERS AND MOTHERS: THE POLITICAL ORIGINS OF SOCIAL POLICY IN THE UNITED STATES 5, 180-93 (1992) (describing early and mid twentieth century political debates concerning universal health care).

<sup>28</sup> Liability insurance, uninsured motorist coverage, Med-pay coverage, and underinsured motorist coverage are the most common types of auto insurance; some states have adopted partial no-fault reforms. JERRY & RICHMOND, *supra* note 26, § 130. State mandates for each are enumerated at text accompanying notes 72-79.

<sup>29</sup> 42 U.S.C. §§ 18091(2)(C), 18091(2)(I) (2006 & Supp. IV). *See generally* KENNETH S. ABRAHAM & DANIEL SCHWARCZ, HEALTH CARE SUPPLEMENT TO ABRAHAM'S INSURANCE LAW & REGULATION 12 (5th ed. 2010).

<sup>30</sup> ABRAHAM & SCHWARCZ, *supra* note 29, at 6.

<sup>31</sup> Michael Isikoff, *White House used Mitt Romney health-care law as blueprint for federal law*, MSNBC.COM (Oct. 11, 2011, 6:05 AM), [http://www.msnbc.msn.com/id/44854320/ns/politics-decision\\_2012/t/](http://www.msnbc.msn.com/id/44854320/ns/politics-decision_2012/t/); *Health Care: Mass Observation: Health reform in Massachusetts, the Model for Barack Obama's version, still has a long way to go before it proves itself*, ECONOMIST, June 25, 2011, at 37. ROBERT W. SIEFERT & ANDREW P. COHEN, RE-FORMING REFORM: WHAT THE PATIENT PROTECTION AND AFFORDABLE CARE ACT MEANS FOR MASSACHUSETTS 48 (U. Mass. Medical Center for Health Law and Economics & Blue Cross Blue Shield of Massachusetts Foundation 2010) (federal law modeled on Massachusetts' law); 111 Cong. Rec. H 13119 (Nov. 18, 2009) (statement of Rep. Stearns) ("In Massachusetts, for example—the public option here in

Major problems that drove the national reform were the large number of uninsured Americans, the increasing costs and spending, and the uneven quality of health care in the U.S.<sup>32</sup> Millions of uninsured people receive health care for free, since laws, customs, and professional obligations have long mandated hospitals and providers provide care even if a patient cannot pay.<sup>33</sup> Their bills often are uncollectible.<sup>34</sup> These costs are passed on to the government and private insurers; private insurers raise their premiums.<sup>35</sup> As Justice Ginsberg stated: “The net result: Those with health insurance subsidize the medical care of those without it. As economists would describe what happens, the uninsured ‘free ride’ on those who pay for health insurance.”<sup>36</sup> Moreover, those without health insurance often do not get preventive medical care that could reduce their health care costs later on.<sup>37</sup> States had not and would not be able to solve the problems.<sup>38</sup> The

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Congress is patterned after Massachusetts.”). *See also* 111 Cong. Rec. S 11990 (Nov. 30, 2009) (Statement of Sen. Enzi (“[a]t the beginning of this process, the majority staff of the HELP Committee decided they were going to draft a partisan bill based on the reforms that had recently been adopted in Massachusetts.”)); 111 Cong. Rec. H 12192 (daily ed. Nov. 2, 2009) (statement of Rep. Roe) (“The Massachusetts plan had a noble goal, which was to try to cover as many of its citizens as possible. That’s absolutely what we should try to do in an affordable way. In Massachusetts now, they’re at around 97 percent coverage.”). Some information, including a statement by former Governor Romney, indicates that the Massachusetts health insurance mandate was based on its car insurance mandate. David A. Fahrenthold, *Mass. Bill Requires Health Coverage, State Set to Use Auto Insurance as a Model*, WASH. POST, Apr. 5, 2006 (“Romney said the bill, modeled on the state’s policy of requiring auto insurance, is intended to end an era in which 550,000 go without insurance and their hospital and doctor visits are paid for in part with public funds. ‘We insist that everybody who drives a car has insurance,’ Romney said in an interview. ‘And cars are a lot less expensive than people.’”).

<sup>32</sup> The Census Bureau estimates that 48.6 million Americans were uninsured in 2011. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES 21 (2012), available at <http://www.census.gov/prod/2012/pubs/p60-243.pdf>; BOB LYKE, CONG. RESEARCH SERV., R40517, HEALTH CARE REFORM, AN INTRODUCTION (Apr. 14, 2009). Over forty million Americans did not have health insurance during some part of 2007. *Id.* at 1.

<sup>33</sup> *NFIB v. Sibelius*, 132 S. Ct. at 2611 (Ginsburg, J., concurring in the judgment in part, and dissenting in part).

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* at 2611.

<sup>37</sup> *Id.* at 2611-12.

<sup>38</sup> *Id.* at 2612.



mandate went along with other important reforms which prohibited insurance companies from denying coverage for preexisting conditions or charging more to insure unhealthy than healthy people.<sup>39</sup> Increasing health insurance coverage made eminent sense as a reform goal.<sup>40</sup>

The idea of a federal individual mandate had long been suggested as a way to expand coverage--it was initially proposed by the domestic policy director of the Heritage Foundation in a 1989 lecture published by the Heritage Foundation.<sup>41</sup> The Heritage lecture recognized health insurance as different from other sorts of insurance in that it raised compelling moral issues of societal responsibility. The lecture claimed:

[H]ealth care is different. If a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance. If we find that he has spent his money on other things rather than insurance, we may be angry but we will not deny him services—even if that means more prudent citizens end up picking up the tab. A mandate on individuals recognizes this implicit contract. Society does feel a moral obligation to insure that its citizens do not suffer from the unavailability of health care. But on the other hand, each household has the obligation, to

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<sup>39</sup> These are known as the “guaranteed-issue” and “community rating” provisions. *NFIB v. Sibelius*, 132 S. Ct. 2566, 2585 (2012).

<sup>40</sup> There was not the political will for a single-payer system or a public option. *See infra* note 86. The Affordable Care Act obviously was a political compromise which did not fundamentally change the structure of U.S. insurance markets and did not aggressively tackle issues of quality or cost. *See generally* ABRAHAM & SCHWARCZ, *supra* note 29 at 12-13, 20-21. “Moral hazard” is an important insurance concept that comes into play here. Tom Baker states that the term “‘moral hazard’ typically is used to refer to the theoretical tendency for insurance to reduce incentives (1) to minimize loss or (2) to minimize the cost of a loss.” TOM BAKER, *INSURANCE LAW & POLICY* 4 (2d ed. 2008). The second type, known as “*ex post* moral hazard,” is implicated here. Abraham and Schwarcz outline the “*ex post* moral hazard concern” of health insurance, which is “the risk that individuals who become sick will over-consume health care because they do not pay the full cost of such care,” ABRAHAM & SCHWARCZ, *supra* note 29, at 9-10. The ACA has experimental programs to try to control costs but does little to change the *ex post* moral hazard connected with costs. *Id.* at 21.

<sup>41</sup> Butler, *supra* note 13.

the extent that it is able, to avoid placing demands on society by protecting itself.<sup>42</sup>

President Obama also observed that “[U]nless everybody does their part, many of the insurance reforms we seek—especially requiring insurance companies to cover preexisting conditions—just can’t be achieved,” thus describing it as a way for people to be required to pay their fair share.<sup>43</sup>

There are compelling, insurance-related reasons, often lost in the debate, for having the mandate be one of the ways to increase coverage. The key insurance-related reason for it is to combat “adverse selection,” which is the tendency for people who are disproportionately likely to experience an insured-against event to buy insurance for that event.<sup>44</sup> This leads to a heightened number of claims and increased costs.<sup>45</sup> Adverse selection is a phenomenon in insurance generally and had been common in the individual health insurance market prior to the ACA’s passage.<sup>46</sup> This led companies to have broad exclusions in policies for pre-existing conditions which greatly limited coverage supplied by policies.<sup>47</sup> In the health insurance context, the general adverse selection concern is that people who were healthy would not buy insurance until they thought they were getting sick, and insurance companies extending insurance would not know the buyers’ exact health status; then cost projections would be

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<sup>42</sup> Butler, *supra* note 13, at 6. Butler stated immediately before the passage quoted above that the Heritage proposed federal individual mandate “assumes that there is an implicit contract between households and society, based on the notion that health insurance is not like other forms of insurance protection. If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car. But health care is different.” *Id.*

<sup>43</sup> President Barack Obama, Remarks to a Joint Session of Congress on Health Care (Sept. 10, 2009), *supra* note 13.

<sup>44</sup> BAKER, *supra* note 40, at 6 (noting that adverse selection in this context generally refers to “the (theoretical) tendency for high-risk people to be more interested in insurance than low-risk people.” Mark Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PENN. L. REV. 1825, 1841 (2011) (mandate essential to combat adverse selection). ABRAHAM & SCHWARCZ, *supra* note 29, at 12 (purpose of mandate is to combat adverse selection).

<sup>45</sup> BAKER, *supra* note 40, at 6.

<sup>46</sup> See ABRAHAM & SCHWARCZ, *supra* note 29, at 11 (In the individual market, prior to the ACA, because of adverse selection concerns, almost all policies had preexisting condition exclusions.).

<sup>47</sup> *Id.* at 5, 11.

inaccurate, payouts would be excessive, and costs would skyrocket.<sup>48</sup> The ACA itself explains:

[I]f there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize the adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage for pre-existing conditions can be sold.<sup>49</sup>

In other words, the mandate's goal, which was part of the larger reforms, is to broaden the risk pool so that insurance markets can work better for the benefit of consumers.<sup>50</sup>

This broadening of the risk pool was well explained by Justice Ginsburg:

In the fullness of time...today's young and healthy will become society's old and infirm. Viewed over a lifespan the costs and benefits even out: The young who pay more than their fair share currently will pay less than their fair share when they become senior citizens...And even if, as undoubtedly will be the case, some individuals, over their lifespans, will pay more for health insurance than they receive in health services, they have little to complain about, for that is how insurance works. Every insured person of the covered class will ultimately need that protection.<sup>51</sup>

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<sup>48</sup> Hall, *supra* note 44, at 1841.

<sup>49</sup> 42 U.S.C.A. § 18091(a)(2)(I) (West 2010). ABRAHAM & SCHWARCZ, *supra* note 29, at 20.

<sup>50</sup> 42 U.S.C.A. § 18091(a)(2)(I) (West 2010). *See generally* Bagley & Horwitz, *supra* note 26.

<sup>51</sup> NFIB v. Sibelius, 132 S. Ct. 2566, 2620 (2012). The Commerce Clause section of Justice Ginsburg's opinion in which this language is found is of course a dissent, but it is relevant here both because the mandate was upheld and because her analysis focuses on the health insurance aspects of the Affordable Care Act

The ACA mandate arose from an urgent situation where reform was needed for many reasons; these reasons included a huge number of uninsured people and the costs imposed on the insured by the uninsured.<sup>52</sup> Having a mandate that gives an incentive for people to purchase health insurance, in order to extend coverage and reduce adverse selection, was a positive policy reform.

## 2. Auto Insurance Mandates

Auto insurance mandates, which developed over decades, have a variety of goals.<sup>53</sup> The goals include protecting drivers from tort judgments for damages caused by their negligence, making a pool of money available to compensate for injuries caused by negligently driven automobiles, compensating drivers for injuries caused by uninsured and underinsured drivers, and making sure medical expenses from car accidents are paid for.<sup>54</sup> The development and spread of cars in the United States in the first half of the twentieth century created many challenges.<sup>55</sup> Cars, in addition to being wonderful instruments of transportation, were mobile instruments of destruction which easily could kill or maim.<sup>56</sup> Injuries and death caused by cars were legion, and the best way to encourage safety, provide financial security for drivers, passengers, and pedestrians, and compensate for injuries caused by cars was not obvious.<sup>57</sup> After decades of legislative experimentation and industry opposition, the current web of mandates developed to deal with cars—an expensive and injury-causing necessity.<sup>58</sup>

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which is pertinent to this article. *Id.* at 2617-18. In contrast, the majority sees insurance as simply another product. *Id.* at 2586-87, 2590-91.

<sup>52</sup> See *supra* text accompanying notes 29-40.

<sup>53</sup> See discussion *infra* Part III (discussing the history of auto insurance mandates).

<sup>54</sup> See generally KENNETH S. ABRAHAM, *THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11* 85-104 (2008) [hereinafter *LIABILITY*]; Simon, *supra* note 27.

<sup>55</sup> See generally *LIABILITY*, *supra* note 54.

<sup>56</sup> See generally Simon, *supra* note 27. In fact some thought there should be strict liability for auto injuries under a dangerous instrumentality theory. *Id.* at 562. S. Lochlann Jain, “*Dangerous Instrumentality*”: *The Bystander as Subject in Automobility*, 19 *CULTURAL ANTHROPOLOGY* 61, 61-94 (2004). Most people lacked health and disability insurance and injuries were common, so that injuries were likely to be calamitous. *LIABILITY*, *supra* note 54, at 72-73.

<sup>57</sup> Simon, *supra* note 27.

<sup>58</sup> *LIABILITY*, *supra* note 54, at 78-103.

Mandates have proven to be a workable policy approach to the complex issues presented by the injuries caused by cars.<sup>59</sup>

Driving can lead to injuries that have costs of various types, including injuries that a careless driver causes and injuries that a faultless driver suffers. These injuries are hard to predict in advance and their costs may be astronomical. Other than a very few rich people, no one can be certain that she has the money available to cover those unexpected events. Mandatory auto insurance turns many accidents that would be financial disasters into mere inconveniences.<sup>60</sup>

Without mandates, adverse selection, described above, can occur.<sup>61</sup> People who know they are most at risk for a particular harm will tend to buy insurance, while those who are at lower risk will tend not to buy it. What then can happen is that insurance companies' costs are higher than expected, which results in rate increases or company failure.<sup>62</sup>

In the auto insurance context, adverse selection is rarely discussed because of auto insurance individual mandates which by definition minimize adverse selection.<sup>63</sup> But if there were no individual mandates, adverse selection could easily arise -- dangerous but wealthy drivers who fear tort judgments might seek liability insurance to protect their assets in case they injure someone through their carelessness. At the same time, people who are confident in their own carefulness might choose not to buy liability insurance. That might make the liability insurance pool more full of risky drivers than insurance companies anticipated, resulting in higher-

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<sup>59</sup> *Id.* at 102. This is not to say that mandates are perfect. *See infra* note 65.

<sup>60</sup> LIABILITY, *supra* note 54, at 102.

<sup>61</sup> *See supra* text accompanying notes 44-46.

<sup>62</sup> *See supra* p. 34.

<sup>63</sup> Leah Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 OHIO ST. L.J. 835, 888 (1986) (noting that since car insurance is mandatory, adverse selection concerns are lessened); *See* Robert Hockett, *Making Sense of the Health-Care Reform Debate*, 53 CHALLENGE 28, 44 (Jan-Feb 2010) (“[A] principal means of avoiding the adverse selection problem is by requiring participation by all, in order that no particular inference need be drawn from somebody’s seeking to participate. But only the state has authority to require that people participate in insurance pools—as states routinely do, for example, with driver’s insurance, social security, and Medicare...[I]n requiring participation in such insurance pools, government is doing more than addressing the adverse-selection obstacle to well-functioning insurance arrangements. It is also preventing a form of free-riding—for example, that of uninsured motorists upon the coverage of insured motorists.”).

than-predicted costs.<sup>64</sup> This could further result in skyrocketing rates and insurance company failure. Further, if many drivers do not buy insurance, rates go up for those who do, and the victims of many accidents go uncompensated, which spreads the costs throughout society. But even very careful drivers must buy auto liability insurance. After all, they might be careless and cause an accident that they could not pay for – even though that is unlikely. Their liability insurance keeps them from financial ruin and helps compensate the injured person. If the careful driver's insurance does not cover the accident costs, and the driver cannot afford those costs out-of-pocket, the costs fall only on the victim or are passed on to society. Combating adverse selection through individual auto insurance mandates which allow competition and comparison shopping has proven to be workable, successful policy.<sup>65</sup>

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<sup>64</sup> Since there are mandates this is necessarily hypothetical, but it logically follows from the concept of adverse selection. Wortham, *supra* note 63 (noting that since car insurance is mandatory, adverse selection concerns are lessened).

<sup>65</sup> Of course, auto insurance mandates are not a perfect solution to the problems they tackle; nor is there a perfect solution. They may have inflationary effects on health costs. LIABILITY, *supra* note 54, at 103. They may lead to more accidents than there would be without insurance because of the “moral hazard” effect of having liability coverage. Alma Cohen & Rajeeve Dehejia, *The Effect of Auto Insurance and Accident Liability Laws on Traffic Fatalities*, 47 J.L. & ECON. 357, 357 (2004) (arguing that auto insurance mandates have led to increases in fatalities due to moral hazard effect of insurance). For discussion of “moral hazard” concept, see *supra* note 40. Auto insurance mandates (and the way they are priced) may encourage more driving than is environmentally beneficial. See generally Jennifer B. Wriggins, *Automobile Injuries as Injuries with Remedies: Driving, Insurance, Torts, and Changing the ‘Choice Architecture’ of Auto Insurance Pricing*, 44 LOY. L.A. L. REV. 69, 73-80 (2010). There are persistent equity issues in the way insurance companies classify risk. See, e.g., *King v. Meese*, 743 P.2d 889 (Cal. 1987) (classification by insurance companies of safe drivers who live in South Central Los Angeles as high risk drivers, and requiring them therefore to pay more is constitutional). See generally KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* (1986) [hereinafter *DISTRIBUTING RISK*]; Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517 (1983); Wortham, *supra* note 63.

B. BOTH TYPES OF MANDATE REQUIRE PEOPLE TO INSURE THEMSELVES AGAINST RISKS THEY MAY WANT TO BEAR THEMSELVES

1. ACA individual mandate

A person may want to set aside the money that she may need to pay medical and hospital bills if she becomes ill or has an accident, rather than purchase insurance in advance. This is known as self-insuring.<sup>66</sup> For example, Kaj Ahlberg, one of the individual plaintiffs in *Florida v. U.S. Department of Health and Human Services*, which was also decided as part of *NFIB v. Sibelius*, filed a declaration stating he has no health insurance and has “no desire or intention to buy health insurance in the future, as I am now and reasonably expect to remain, financially capable of paying for my and my family’s health care services out of my own resources as needed.”<sup>67</sup> Plaintiff Ahlberg also stated that he thought health insurance was not a “sensible or acceptable” use of his financial resources.<sup>68</sup> This idea that a person should be able to self-insure for medical costs deeply resonates with the freedom and coercion arguments that underlay the plaintiffs’ Commerce Clause arguments.<sup>69</sup> But if a person is one of those affected by the ACA individual mandate, her choice to self-insure will have a cost—she will have to either buy health insurance or make the

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<sup>66</sup> Robert Jerry and Douglas Richmond explain as follows: “Sometimes people cope with risk through self-insurance. For example, a restaurant owner, cognizant of the possibility that a person may contract food poisoning, is likely to take substantial preventive measures to limit the risk of such an occurrence. After taking such steps, a remote risk nonetheless exists that a customer might be poisoned. The owner may calculate that such an event will rarely occur and may conclude that if it does occur the damages associated with such an event could easily be paid from the owner’s assets. Alternatively, the owner may choose to set aside a portion of each year’s profits into a reserve fund designated to pay the loss should it occur. In either case, the owner chooses to bear the risk. This is the essence of self-insurance.” JERRY & RICHMOND, *supra* note 26, § 10.

<sup>67</sup> Declaration of Kaj Ahlburg in Support of Plaintiffs’ Motion for Summary Judgment, ¶ 4, *Florida v. U.S. Dept. of Health and Human Services*, Case No.: 3:10-cv-91-RV/EMT, U.S.D.C., N.D. Fla. Pensacola, Order Granting Summary Judgment, 15. Similarly, Mary Brown’s declaration stated that she “is subject to the individual mandate and objects to being required to comply as she does not believe the cost of health insurance is a wise or acceptable use of her resources.” *Id.* at 14 (quoting Mary Brown’s declaration).

<sup>68</sup> Ahlburg declaration, *supra* note 67, at ¶ 7.

<sup>69</sup> See *supra* notes 8-10 and accompanying text.

Shared Responsibility Payment.<sup>70</sup> For those to whom the ACA mandate applies, the government is telling people they are not allowed to “freely” bear risks that they might want to, and might be perfectly capable of, bearing themselves.

## 2. Auto insurance individual mandates

A driver may want to set aside the money that she will have to pay if she injures someone through negligence rather than purchase insurance to cover that risk. She may currently be able to, and expect to remain able to pay for harm she might cause through her carelessness, so she may want to self-insure against that risk. But the requirements in 49 states that she buy liability insurance before registering a car and driving, on pain of civil or criminal penalties,<sup>71</sup> covering what she would have to pay if she injured someone through negligence, deny her that “free” choice of setting aside the funds in advance.<sup>72</sup>

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<sup>70</sup> See *infra* text accompanying notes 122-27 (discussing the Shared Responsibility Payment); see *infra* Part II (discussing choice and coercion as ways to distinguish between auto insurance mandates and the ACA mandate).

<sup>71</sup> INSURANCE INFORMATION INSTITUTE, *Compulsory Auto/Uninsured Motorists* (Feb. 2013), <http://www.iii.org/media/hottopics/insurance/compulsory> (49 states and the District of Columbia in 2012 had mandatory liability auto insurance). State laws require drivers to purchase liability coverage in specified minimum amounts. JERRY & RICHMOND, *supra* note 26, § 132. New Hampshire does not require every driver to purchase liability insurance but does require all drivers to show they are financially responsible and requires drivers who have been convicted of driving under the influence to purchase liability insurance. N.H. REV. STAT. ANN. § 264 (LexisNexis 2011). According to one treatise published in 1974, around the time many insurance mandates were passed, liability insurance is aimed at alleviating two major problems: “1. Protecting the tortfeasor of an automobile accident from financial disaster resulting from a judgment rendered against him in a court of law. 2. Providing compensation for the victim of an accident for injuries received from the accident.” M.G. WOODRUFF III, JOHN R. FONSECA & ALPHONSE M. SQUILLANTE, *AUTOMOBILE INSURANCE AND NO-FAULT LAW* § 3:1 (1974). See CALVIN H. BRAINARD, *AUTOMOBILE INSURANCE* 16 (Richard D. Irwin, Inc. ed., 1961) (liability coverage has dual purpose of protecting the finances of the insured and the victim).

<sup>72</sup> Liability insurance “pays proceeds to a third party to whom an insured becomes liable.” BAKER, *supra* note 40, at 23. Liability insurance pays, on behalf of a negligent driver, money that the negligent driver owes to his victim up to a set limit purchased in advance. JERRY & RICHMOND, *supra* note 26, at 924. Enforcement is through the torts system. *Id.*



Similarly, this same driver may want to set aside the money for a different risk, namely the risk that she or a passenger will suffer injuries from a negligent driver who does not have insurance or who is a hit-and-run driver. This driver who wants to self-insure may think that the risk of being injured by a hit-and-run or uninsured driver is low, that she has sufficient resources to cover her and her passengers' injuries in that kind of a situation, and that purchasing insurance to cover that risk is a waste of money.<sup>73</sup> However, laws in twenty-two jurisdictions require that this driver buy insurance for the risk to herself and her passengers from being struck by an uninsured or hit-and-run driver; this is known as uninsured motorist coverage.<sup>74</sup>

Laws in a few states will tell this same motorist that even if she does not want to buy insurance coverage for her own or her passengers' medical bills, she must buy it (up to a certain limit).<sup>75</sup> And laws in eight states tell this driver that she also must buy insurance to cover the risk that she (or her passengers) will be injured by a driver who does not have

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<sup>73</sup> Perhaps she has excellent health insurance and disability insurance, and she would rather self-insure against these risks than purchase insurance for them.

<sup>74</sup> Insurance protecting drivers from risks created by other drivers who may lack insurance is known as uninsured motorist coverage. ALAN I. WIDISS & JEFFREY E. THOMAS, *UNINSURED AND UNDERINSURED MOTORIST INSURANCE* 8 (3d ed. 2005). Twenty-one states and the District of Columbia require drivers to purchase it. See INSURANCE INFORMATION INSTITUTE, *Compulsory Auto/Uninsured Motorists* (Feb. 2013), <http://www.iii.org/media/hottopics/insurance/compulsory>; Memo from Christopher Harmon to Jennifer Wriggins August 24, 2012 (twenty-one states and the District of Columbia require uninsured motorists coverage; Insurance Information Institute Memo does not list Connecticut) (on file with the author); WIDISS & THOMAS, *supra*, at 8; 6 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 61.02[3][a][ii] (Christopher J. Robinette ed. 2012). For more detail on uninsured motorist coverage and its historical development see *infra* note 159.

<sup>75</sup> This is known as Med-Pay coverage. LIABILITY, *supra* note 54, at 79-80. It is required for all drivers in Colorado, Maine, and Pennsylvania. COLO. REV. STAT. § 10-4-635 (2012) (passed in 2004), ME. REV. STAT. tit. 29 § 1605-A (2012) (Maine, passed in 1997), 75 PA. CONS. STAT. ANN. § 1711 (West 2006) (passed in 1984). New Hampshire requires that auto liability policies contain Med-Pay coverage, although New Hampshire is the only state that does not require all drivers to purchase liability coverage. N.H. REV. STAT. ANN. § 264:16 (LexisNexis 2011) (passed in 1971). See LIABILITY, *supra* note 54, at 79-80 (noting Med-Pay coverage began in mid-twentieth century and allowed coverage of medical expenses before health insurance became widespread).

sufficient insurance to cover her or her passengers' injuries.<sup>76</sup> Finally, laws in sixteen states require her to buy "no-fault" coverage that covers part of accident expenses regardless of driver carelessness.<sup>77</sup> Again, even if this driver is currently, and expects to remain able to cover the potential costs, she is not allowed to do that without risking civil or criminal penalties in the states where this coverage is required.

States have long legislated that individuals may not decide to self-insure against many risks of auto use, including risks to themselves, their passengers, or their own assets. While some of these are risks to others, some are risks to the driver herself. Mandatory car insurance, in all its various forms,<sup>78</sup> is an example of the government telling drivers that they are not allowed to bear risks that they might want to, and might be perfectly capable of, bearing themselves.<sup>79</sup>

C. BOTH TYPES OF MANDATES REQUIRE THAT RISKS BE TRANSFERRED AND SPREAD, WHICH IS FUNDAMENTALLY WHAT INSURANCE DOES

The various mandates require transfer and spreading of risk, which are essential yet often forgotten aspects of insurance.<sup>80</sup>

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<sup>76</sup> This is known as "underinsured motorist coverage." WIDISS & THOMAS, *supra* note 74, § 31.4. Eight states mandate that drivers buy this coverage, so that if they are harmed by a careless driver who does not have sufficient liability insurance to cover their injuries, they will have sufficient coverage under their own 'underinsured motorist' coverage. NEW APPLEMAN ON INSURANCE, *supra* note 74, at VOL. 6 § 61.02[3][a][ii].

<sup>77</sup> See INSURANCE INFORMATION INSTITUTE, *supra* note 74. This no-fault coverage often is known as Personal Injury Protection (PIP) and can cover medical expenses, lost wages, and rehabilitation expenses depending on the state. JERRY & RICHMOND, *supra* note 26, § 132.

<sup>78</sup> The forms mentioned above are liability insurance, uninsured motorist coverage, Med-Pay coverage, underinsured motorist coverage, and no-fault elements. See *supra* notes 71-77 and accompanying text.

<sup>79</sup> For discussion of choice and coercion in the two contexts, see *infra* Part II.

<sup>80</sup> According to insurance scholar Tom Baker, "[A] risk transfer is...a transaction or institutional arrangement that transfers, or shifts, risk from one person or entity to another...[R]isk spreading occurs whenever an entity takes on risk and parcels it out to a group of people. Insurance is the paradigmatic risk-spreading institution. Many people pay relatively small amounts of money so that there is a large pot of money to cover the costs of the unfortunate few who suffer a loss." BAKER, *supra* note 40, at 2. Insurance scholar Kenneth Abraham describes the same process with somewhat different terminology: "[I]nsurance is a method

### 1. ACA individual mandate

Congress chose to approach health care reform with a private insurance framework rather than public funding; this meant that risk-sharing between individuals was an essential aspect of the plan. If I am one of those affected by the mandate, the premiums that someone else pays may end up benefitting me if I become a victim of a disease or injury.<sup>81</sup> Those premiums will help pay the hospitals and doctors that provide medical care for me, and they may total much, much more than the cost of my premiums. Correlatively, health insurance premiums that I pay may wind up benefitting not me but someone else who is a victim of a disease or injury. This pooling and transferring of risk is the essence of insurance.<sup>82</sup>

### 2. Auto insurance individual mandates

States have chosen to respond to the myriad injury problems caused by autos through a private insurance framework rather than public funding. Having liability insurance means that other people's premiums may end up benefitting me if I cause an accident through carelessness, because the premiums other people have paid for their liability insurance may be used to help pay the judgment or settlement that compensates for the injury I caused through carelessness.<sup>83</sup> Also, other people's premiums may help me if I am a victim of an accident caused by someone else's carelessness, since those premiums will help pay for the compensation I receive from the injurer's liability policy. Alternatively, my premiums may

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of managing risk by distributing it among large numbers of individuals or enterprises." ABRAHAM, *supra* note 65. See NFIB v. Sibelius, 132 S. Ct. 2566, 2620 (2012) (Ginsberg, J., dissenting) (noting "that is how insurance works.").

<sup>81</sup> As Tom Baker explains, "[m]any, perhaps most, people in the United States never realize that, if they are lucky, most of their premiums for most forms of insurance will go to pay other people's claims. Indeed, one of the most common images of insurance is quite similar to that of a savings account....[People] often expect that over the course of a lifetime the deposits made by each person should roughly equal the withdrawals on that person's insurance account....[W]hen it comes to health, disability, property, and term life insurance, if your withdrawals equal your deposits, you have had, at least in some respects, a very unfortunate life. If you are fortunate, your insurance dollars go to pay other people's claims." BAKER, *supra* note 40, at 14.

<sup>82</sup> *Id.* at 2, 14.

<sup>83</sup> *Id.* at 14 (describing how one's insurance premium dollars may go to pay others' claims, or vice versa).

end up benefitting not me but someone who negligently causes an accident or a victim who suffers an injury from someone else's carelessness. This sharing and shifting of risk is what insurance does.

D. BOTH TYPES OF MANDATE REQUIRE PEOPLE TO BUY SOMETHING FROM A PRIVATE SELLER

Both mandates require people to buy something from a private seller since they are based on the very American idea that competition among insurance companies, combined with laws requiring coverage, will benefit consumers more than having a government program alone deal with the situation.<sup>84</sup>

1. ACA individual mandate

Congress could have chosen to fund health care costs in a different way, for example through universal public insurance funded through its power to tax. It could have expanded existing government health care funding such as the Medicare and Medicaid programs that currently provide health care to millions who fit specific eligibility criteria

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<sup>84</sup> Workers compensation legislation takes a somewhat similar, private-public approach to insurance for workers' injuries. In every state but Texas, employers of a certain size must participate. 1 LARSON'S WORKERS' COMPENSATION LAW § 2.06, at 2-12 (MATTHEW BENDER & CO. 2009), VINCENT R. JOHNSON & ALAN GUNN, STUDIES IN AMERICAN TORT LAW 651 (4th ed. 2009) (noting that participation in Texas is optional but encouraged). In most states, employers obtain insurance through the private market. LIABILITY, *supra* note 54, at 60. Fourteen states have a "public option" of state-run insurance that competes with private insurers, while six states have government-run funds that monopolize the field of coverage. *Id.* at 60-61. The large majority of states allow employers to self-insure for groups. Christine Fuge, *The Workers Compensation Self-Insurance Decision*, INT'L RISK MGMT'G INS. (Aug. 2001), available at <http://www.irmi.com/expert/articles/2001/fuge08.aspx>. This approach to workers compensation is what Professor Abraham calls a "mixed public-private insurance approach," and contrasts with systems in other countries where workplace injury costs are compensated through their social welfare systems. LIABILITY, *supra* note 38, at 61. See generally SKOCPOL, *supra* note 27, at 285-302 (describing history of workers compensation reforms and particularly the failure of more comprehensive policies), JOHN FABIAN WITT, THE ACCIDENTAL REPUBLIC: CRIPPLED WORKINGMEN, DESTITUTE WIDOWS, AND THE REMAKING OF AMERICAN LAW (2004) (outlining history of workers compensation legislation). For further discussion of workers compensation law history, see *infra* note 180.

to cover everyone.<sup>85</sup> But that would have been dramatically different from the ACA, which largely leaves the system of governmental provision of health insurance in place and adopts a mostly privatized system for health care not covered by governmental programs.<sup>86</sup> One of the goals of the ACA and the mandate was to increase competition and choice for the benefit of consumers.<sup>87</sup> It will use a system of state exchanges which will allow variations between states as to basic requirements for policies and will allow consumers to comparison shop for policies that are most beneficial for them and their families.<sup>88</sup> Since the mandate does not go into effect until 2014, at the present one cannot point to existing increased competition for customers.

## 2. Auto insurance individual mandates

It would be possible to have the losses caused by car accidents be paid for in a totally different way, perhaps through a no-fault insurance plan or government programs funded by tax revenue.<sup>89</sup> But legislatures have decided that mandates setting a floor for coverage and mandates that

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<sup>85</sup> ABRAHAM & SCHWARCZ, *supra* note 29, at 5.

<sup>86</sup> *Id.* The mandate was far from a single-payer system and did not even include a public option. Shalagh Murray & Lori Montgomery, *Senate Democrats Largely Support Health Care Deal that Drops Public Option*, WASH. POST, Dec. 10, 2009, at A1; *see also Dems Make Deal to Drop Public Option*, CBS NEWS (Dec. 9, 2009, 12:35 PM), [http://www.cbsnews.com/2100-250\\_162-5943452.html](http://www.cbsnews.com/2100-250_162-5943452.html).

<sup>87</sup> *See Putting Americans in Control of Their Health Care*, WHITEHOUSE, Title I. *Quality, Affordable Health Care for all Americans*, WHITEHOUSE.GOV, [whitehouse.gov/health-care-meeting/proposal/titlei](http://whitehouse.gov/health-care-meeting/proposal/titlei) (last visited Feb. 17, 2013) (“Americans without insurance coverage will be able to choose the insurance coverage that works best for them in a new open competitive insurance market—the same insurance market that every member of Congress will be required to use for their insurance...”).

<sup>88</sup> *See supra* note 87; Louise Radnofsky, *Puzzling Over What to Call State Insurance Exchanges*, WALL ST. J., Aug. 7, 2012, at A7; ABRAHAM & SCHWARCZ, *supra* note 29, at 15.

<sup>89</sup> In fact, a no-fault plan modeled on workers compensation insurance (known as the Columbia Plan) was proposed in 1932 by prominent experts but it never became law in any state. Simon, *supra* note 27, at 585-87; LIABILITY, *supra* note 54, at 4-7. Other efforts to replace the liability system for auto accidents with a no-fault system did not lead to comprehensive reform. *Id.* at 92-100. For a recent analysis of the failure of no-fault to spread more widely, *see* Nora Freeman Engstrom, *An Alternative Explanation for No-Fault's "Demise,"* 61 DEPAUL L. REV. 303 (2012).

companies cover high-risk drivers, together with competition among companies and the common law theory of negligence liability are the best way to approach the funding of the costs of accidents.<sup>90</sup> Auto insurance mandates have led to fierce competition and continued innovation.<sup>91</sup> They exemplify how government mandates coupled with private competition have resulted in a successful system which extends coverage and shares risk very broadly, bringing many benefits to consumers.<sup>92</sup>

#### E. CONCLUSION

There are significant similarities between the mandates. First, they both are ways to tackle public policy dilemmas that have no easy solution, and there are strong policy reasons for mandates in each context. Second, they direct people to insure themselves against risks they may want to handle through setting money aside rather than through buying insurance. Third, they require that risks be pooled and transferred, which is a fundamental function of insurance. Fourth, they both are based on the very American idea that, rather than a government takeover of a problem, competition among private companies, together with laws requiring coverage and regulating insurance, will benefit the public more. In the auto context, mandates have developed into system which is so workable and widely accepted that most people do not think about it much.<sup>93</sup> The parallels between the two types of requirements are striking, and show that

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<sup>90</sup> Each state has a high risk plan which requires insurance companies to offer coverage to drivers considered too risky to insure. *See infra* notes 112-16 and accompanying text. Liability for car accidents has long been based on the common law theory of negligence. Simon, *supra* note 27, at 561; JERRY & RICHMOND, *supra* note 26, at §§ 131-32. However, cases almost always settle and treatment of claims is generally routinized and without deep inquiry into fault. *See generally* Nora Freeman Engstrom, *Sunlight & Settlement Mills*, 86 N.Y.U. L. REV. 805 (2011) (describing how routinization distances damage determinations from fault determinations).

<sup>91</sup> *See e.g., Deregulating Auto Insurance: Hearing Before H. Comm. on Financial Services, Subcommittee on Oversight and Investigation* (Aug. 1, 2001) (statement of Robert E. Litan, Vice President, Economic Studies Program at Brookings Institution), available at [http://www.brookings.edu/testimony/2001/0801business\\_litan.aspx](http://www.brookings.edu/testimony/2001/0801business_litan.aspx) (testimony stating that insurance for automobiles is a competitive market, and with the advent of the internet it will be more so); JERRY & RICHMOND, *supra* note 26, at 918-19 (describing pay-as-you-drive developments). *See infra* note 169.

<sup>92</sup> *See infra* pp. 37-39.

<sup>93</sup> LIABILITY, *supra* note 54, at 102.

the ACA individual mandate is neither the anomaly nor the unprecedented intrusion on individual freedom which its opponents claim.<sup>94</sup> This in turn leads which leads to discussion of the claim that auto insurance mandates are completely distinguishable because driving is a choice.

### III. CHOICE, FREEDOM, AND COERCION

The most common response to the example of car insurance mandates as precedents is that auto insurance mandates are totally different because driving is a choice.<sup>95</sup> This “choice rejoinder” of mandate critics asserts that one can choose to drive or not to drive and government can regulate because driving is a choice.<sup>96</sup> By contrast, there is no choice in the ACA mandate context; one must buy the insurance simply because one is alive.<sup>97</sup> Critics claim that the ACA mandate is deeply coercive, in contrast to auto insurance mandates.<sup>98</sup> This Part will show that the line between choice and coercion does not track the two kinds of mandates in that way. First, driving often is not a choice but a necessity, as cases and statutes

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<sup>94</sup> See, e.g., Barnett/Heritage Memo, *supra* note 13.

<sup>95</sup> See, e.g., Michael Tanner, *Individual Mandates for Health Insurance: Slippery Slope to National Health Care*, CATO INSTITUTE (Policy Analysis No. 568), Apr. 5, 2006, at 10 n.13 (“If one does not like the regulations, including an insurance mandate, one can choose not to drive. A health insurance mandate would not generally give people such a choice.”); Barnett/Heritage Memo, *supra* note 13, at 6; *America’s Newsroom*, Interview by Bill Henner with George Pataki, former N.Y. Governor (FOX Television Broadcast Sept. 6, 2010) (Former Governor George Pataki of New York was asked in a September 2010 interview, ‘what’s the difference between being required to carry auto insurance and the requirement to carry health insurance?’ He responded: The difference is, if you want to drive a car on a public street in this country, you are asking the government for the right to do something. You don’t have a right to go on a public highway. And when you do go on a public road, you can pose [] risk to someone else out there. So clearly the government has the right to say that you should know how to drive and you should have insurance if you do. But the health-care bill says, if you don’t want to do anything, if you just want to sit home and not participate, we’re going to fine you, because we’re going to make you participate in this program,’ Interviewer: ‘So, it is mandatory participation, it’s not voluntary as is the case when you choose to drive a car?’ Mr. Pataki: ‘When you choose to drive.’).

<sup>96</sup> See *supra* note 95.

<sup>97</sup> See *supra* note 95.

<sup>98</sup> See, e.g., Barnett/Heritage Memo *supra* note 13, at 6; Tanner, *supra* note 95; *America’s Newsroom*, *supra* note 95.

have long recognized.<sup>99</sup> Second, for those to whom the ACA mandate might apply, there is a choice between buying insurance and making a Shared Responsibility Payment, which is not different in kind from other government incentives and taxes.<sup>100</sup> Third, auto insurance mandates actually are more coercive than the ACA mandate.<sup>101</sup> In short, the ACA mandate involves less coercion and more choice than its opponents claim, and car mandates involve more coercion and less choice than is commonly recognized. Therefore, the ACA mandate cannot be dismissed as coercive while accepting car insurance mandates as not coercive.

A. DRIVING IS NOT A PURE “CHOICE”

Characterizing driving as a pure choice has no footing in the reality of most Americans’ lives. Former Massachusetts Governor Mitt Romney articulated this in a 2011 interview: “[T]he government of course has a lot of mandates, and I know folks don’t like that—mandates kids go to school, mandates they have to have auto insurance if they have an automobile. And my conservative friends say, well, we don’t have to have automobiles; well what state do you live in? Of course you have to have automobiles in this nation.”<sup>102</sup> Romney’s point is simply that automobiles and driving are necessities in the U.S. Driving is very often not a pure choice but rather is essential for making a living and just for living; it is a constrained decision shaped not only by individuals and households but by government policy at all levels.<sup>103</sup>

Cases and statutes have long recognized that driving is not an ‘extra’ or a choice, but that it is necessary for people to be able to earn a living. For example, in the context of drivers’ licenses, the United States Supreme Court wrote that once the state issues licenses, “their continued

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<sup>99</sup> See *infra* Part II.A.

<sup>100</sup> See *infra* Part II.B.

<sup>101</sup> See *infra* Part II.C.

<sup>102</sup> *The O’Reilly Factor*, Interview by Bill O’Reilly with Former Governor Mitt Romney, Presidential Candidate (FOX Television Broadcast, Sept. 13, 2011).

<sup>103</sup> It is true that in some parts of the United States such as Manhattan in New York City, driving is not essential. But those parts are the exception and tend to be expensive. See Genevieve Guiliano & Susan Hanson, *Managing the Auto*, in *THE GEOGRAPHY OF URBAN TRANSPORTATION* 385 (Susan Hanson & Genevieve Guiliano, eds., 3d ed. 2004) (“The U.S. has the highest rate of private vehicle ownership, the highest level of daily miles traveled and the lowest rates of trip-making by modes other than the auto [in the world.]”).



possession may become essential in the pursuit of a livelihood.”<sup>104</sup> Therefore, procedural due process must be given before a license may be suspended.<sup>105</sup> If the ability to drive had not been an element of “life, liberty, or property,” in this case property, no process would have been due.<sup>106</sup> The Supreme Court also has recognized that many are dependent on driving in order to make a living.<sup>107</sup>

The Supreme Court of Michigan considered driving to be a necessity when determining the constitutionality of comprehensive auto insurance reform in the 1978 case of *Shavers v. Kelley*.<sup>108</sup> Upholding the reforms in general but specifying that auto insurance had to be provided at equitable and fair rates, the court explained as follows:

In Michigan the independent mobility provided by an automobile is a crucial, practical necessity; it is undeniable that whether or not a person can obtain a driver's license or register and operate his motor vehicle profoundly affects important aspects of his day-to-day life.<sup>109</sup>

The court noted that under the law, without insurance, a person could not register her vehicle, and “the interest in registering and operating a vehicle is as significant as the interest in the use of a driver's license.”<sup>110</sup> Therefore, the state's auto insurance laws had to guarantee that rates were not arbitrary or unfair in order to be constitutional.<sup>111</sup>

Every state's laws treat driving as more of a necessity than a choice since every state has a requirement that auto insurers cover high risk

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<sup>104</sup> *Bell v. Burson*, 402 U.S. 535, 539 (1971).

<sup>105</sup> According to Laurence Tribe, the court's decisions in this area have largely abandoned “whatever had remained of the rights-privileges distinction.” LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 666 (2d ed. 1988). See *Goldberg v. Kelly*, 397 U.S. 254, 262 (1970); *Bell*, 402 U.S. at 539.

<sup>106</sup> U.S. CONST. amend. XIV, § 1.

<sup>107</sup> See *Calif. State Auto. Assoc. Inter-Ins. Bureau v. Maloney*, 341 U.S. 105, 107 (1951), discussed *infra* at Part III.B.

<sup>108</sup> *Shavers v. Kelley*, 402 Mich. 554, 598 (1978), *cert denied*, 442 U.S. 934 (1979).

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 599.

<sup>111</sup> *Id.* at 600. The court's decision gave the legislature and the state commissioner eighteen months to ensure that rates were equitable and fair. The Supreme Court denied cert, and there is no further history. See *supra* note 108.

individuals so that those individuals can drive.<sup>112</sup> This is a mandate on insurance companies. Rather than simply allowing insurance companies to deny coverage to risky drivers so that they cannot drive, all states have developed a plan so that high risk drivers can get behind the wheel, backed by insurance.<sup>113</sup> As noted in one treatise: “[t]he need for such a plan is instantly recognizable. The only alternatives are either to impose a disproportionate number of bad risks upon a few insurers . . . or to *disallow these [bad] risks the opportunity to drive. Neither alternative is acceptable to the parties involved.*”<sup>114</sup> If driving was seen as merely optional, this universal market regulation would never have developed.<sup>115</sup> As insurance law professor Kenneth Abraham explains,

[t]he current emphasis on various kinds of residual markets in the automobile insurance field reveals a great deal about the centrality of the automobile in our culture. The use of an automobile at a tolerable cost has become almost a fundamental right; the maintenance of residual markets that assure all drivers minimum insurance coverage follows from and reflects this development.<sup>116</sup>

Although it would be reasonable to exclude high-risk drivers from coverage and thus from driving, no state agrees because of the importance of driving and car access.

On any given day, over two-thirds of Americans aged fifteen and

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<sup>112</sup> “[A]ll states have some kind of high-risk or “residual market plan” through which automobile insurance is sold to people unable to obtain insurance in the voluntary market. The most common mechanism in the states is the “assigned risk plan” under which insurers doing business in a state are required to insure some portion of otherwise uninsurable risks.” JERRY & RICHMOND, *supra* note 26, § 22[e]. This is also known as the involuntary market. Press Release, Ins. Info. Inst. (Jan. 25, 2011), [www.iii.org/issue\\_updates/residual-markets.htm](http://www.iii.org/issue_updates/residual-markets.htm). These requirements and their history are discussed more fully at *infra* Part III.A; litigation about the constitutionality of one state’s high risk plan is discussed more fully at *infra* Part III.B.

<sup>113</sup> See *infra* Part III.

<sup>114</sup> WOODRUFF, FONSECA, & SQUILLANTE, *supra* note 71, § 3:35, at 99 (emphasis added).

<sup>115</sup> See ABRAHAM, DISTRIBUTING RISK, *supra* note 65, at 216, 219. See *infra* Part III.

<sup>116</sup> ABRAHAM, DISTRIBUTING RISK, *supra* note 65, at 219.

older are behind the wheel of a car for at least an hour.<sup>117</sup> Roughly 80% of adult Americans have a drivers' license.<sup>118</sup> The "free choice" to drive is affected by state and federal transportation policy as well as local zoning laws, all of which have a significant impact on the form and character of cities, suburbs, and rural areas.<sup>119</sup> Being able to drive a working car is essential for suburban and rural transportation in the U.S.<sup>120</sup> The respective locations of work, schools, shopping, medical care and housing often leave individuals with no real choice as to whether or not to drive.<sup>121</sup>

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<sup>117</sup> *Spotlight on Statistics: Automobiles*, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/spotlight/2011/auto> (Oct. 2011).

<sup>118</sup> Press release, National Safety Council, Licensed Drivers and Number in Accidents by Age: 2009 (Sept. 30, 2009) (on file with the author) (211 million Americans have drivers licenses).

<sup>119</sup> See Michael Lewyn, *How Government Regulation Forces Americans Into Their Cars: A Case Study*, 19 WIDENER L. J. 839, 839-40 (2007) (showing how zoning and other regulations disadvantage pedestrians); John Pucher, *Public Transportation*, in THE GEOGRAPHY OF URBAN TRANSPORTATION 202, 217 (Susan Hanson & Genevieve Giuliano, eds., 3d. ed. 2004); ANDRES DUANY, ELIZABETH PLATER-ZYBECK, & JEFF SPECK, SUBURBAN NATION: THE RISE OF SPRAWL AND THE DECLINE OF THE AMERICAN DREAM xiii (2000). The Federal policies include the federal guarantee of home mortgages, the home mortgage interest deduction, and federal road building and utility subsidies. Katharine B. Silbaugh, *Women's Place: Urban Planning, Housing Design, and Work-Family Balance*, 76 FORDHAM L. REV. 1797, 1842-49 (2007). State policies include zoning for building type, separate use zoning, and lack of regional planning. *Id.* at 1846-50.

<sup>120</sup> DUANY, ET AL., *supra* note 119, at 25 (cars are essential for life in suburbs); Lisa R. Pruitt, *Missing the Mark: Welfare Reform and Rural Poverty*, 10 J. GENDER, RACE, & JUST. 439, 454-58 (2007) (detailing transportation issues for rural women).

<sup>121</sup> See DUANY ET AL., *supra* note 119. The exact causal mechanisms of sprawl are disputed. See, e.g., ROBERT BRUEGMAN, SPRAWL: A COMPACT HISTORY (2005), JONATHAN LEVINE, ZONED OUT: REGULATION, MARKETS, AND CHOICES IN TRANSPORTATION AND METROPOLITAN LAND-USE (2006). Regardless of the exact causal mechanism, major structural factors sharply constrain individuals' choice. See, e.g., Katharine B. Silbaugh, *Wal-Mart's Other Woman Problem: Sprawl and Work-Family Balance*, 39 CONN. L. REV. 1713 (2007). Moreover, when gas prices rise, polls find many Americans suffer hardship, revealing the speciousness of the notion that driving is an optional activity. See Gary Langer & Gregory Holyk, *Gas Prices Slam Mobility and Obama's Popularity*, ABC NEWS (Apr. 25, 2011), <http://abcnews.go.com/Politics/gas-prices-slam-drivers-obamas-poll-numbers/story?id=13453640> ("with gas prices up 26% to an average of \$3.88 a gallon, seven in ten Americans in this ABC News/Washington Post poll report financial hardship as a result, six in 10 say they have cut back on driving.");

## B. THE ACA INDIVIDUAL MANDATE CREATES A CHOICE

The ACA mandate gives those who are subject to it a choice between obtaining health insurance and paying the ‘Shared Responsibility Payment,’ which is by statute always less than the cost of the insurance.<sup>122</sup> Justice Roberts concluded that the Shared Responsibility Payment was for constitutional purposes a valid tax, and asserted that “imposition of a tax...leaves an individual with a lawful choice to do or not do a certain act.”<sup>123</sup> The lack of additional consequences was significant in determining that the mandate could validly be seen as a tax. He noted that “[n]either the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS. The government . . . confirm[s] that if someone chooses to pay [the Shared Responsibility Payment] rather than obtain health insurance, they have fully complied with the law.”<sup>124</sup> The Shared Responsibility Payment, as Justice Roberts explained, is like many other types of government policy aimed to influence behavior.<sup>125</sup> It makes the decision to self-insure for medical expenses more costly than it would be otherwise.<sup>126</sup> He explained in a

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Michael D. Shear, *High Gas Prices Give G.O.P. Issue to Attack Obama*, N.Y. TIMES (Feb. 18, 2012). Proposals to increase the gas tax, which has not been raised since 1993, consistently have met with defeat because of political opposition. Brian D. Taylor, *The Geography of Urban Transportation Finance*, in THE GEOGRAPHY OF URBAN TRANSPORTATION 294, 307-10. Gas prices in Europe are roughly four times higher than in the U.S., and the large majority of the differential is due to higher gas prices. John Pucher, *Public Transportation*, in THE GEOGRAPHY OF URBAN TRANSPORTATION 207, 217. These responses show that driving is seen as a necessity, as indeed it is. Further, they demonstrate how vacuous it is to assert that the decision whether or not to drive is a pure choice.

<sup>122</sup>NFIB v. Sebelius, 132 S. Ct. 2566, 2595-96 (2012). The shared responsibility payment per individual will be either \$695 indexed for inflation in later years, 26 U.S.C. § 5000A(c)(3)(A) (2010), or 2.5% of household income. *Id.* at § 5000A(c)(2)(B)(iii). For more information see DAVID NEWMAN, CONGRESSIONAL RESEARCH SERVICE, INDIVIDUAL MANDATE AND RELATED INFORMATION REQUIREMENTS UNDER PPACA 8-11 (2011), <http://healthreformgps.org/wp-content/uploads/CRSreportonPPACAug2011.pdf>. For instance, a single individual with no dependents with an income of \$40,000 will pay about \$750 in 2016, whereas the same individual with \$100,000 in annual income will pay about \$2,500. *Id.*

<sup>123</sup> NFIB, 132 S. Ct. at 2600.

<sup>124</sup> *Id.* at 2597.

<sup>125</sup> *Id.* at 2596.

<sup>126</sup> *Id.* at 2597.

footnote:

Of course, individuals do not have a lawful choice not to pay a tax due, and may sometimes face prosecution for failing to do so (although not for declining to make the shared responsibility payment, see 26 U.S.C. §5000A(g)(2)). But that does not show that the tax restricts the lawful *choice* whether to undertake or forgo the activity on which the tax is predicated. Those subject to the individual mandate may lawfully forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes. The only thing they may not lawfully do is not buy health insurance and not pay the resulting tax.<sup>127</sup>

The ACA individual mandate will impose financial costs on some, as do many government activities, but that is a different matter from taking away individual choice.

C. AUTO INSURANCE MANDATES ARE FAR MORE COERCIVE THAN THE ACA INDIVIDUAL MANDATE.

States' auto insurance mandates actually are more coercive than the ACA individual mandate in at least two ways. First is in the reach of the mandates. Auto insurance mandates (and they typically require the purchase of several types of insurance) apply to everyone who is a licensed driver and car owner, requiring drivers to buy insurance they may not want to buy, at the risk of fines or jail sentences.<sup>128</sup> It is probably impossible to accurately estimate the number of people who buy auto liability and other auto insurance solely because of mandates, but it seems safe to say that this figure is probably in the tens of millions.<sup>129</sup> These mandates certainly affect the finances of those subject to them, and they may override decisions about risk and budgets of people who must comply with them (i.e. all

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<sup>127</sup> *Id.* at 2600 n.11 (emphasis added). See *supra* Part II.

<sup>128</sup> See *supra* notes 34-40 and accompanying text.

<sup>129</sup> With an estimated 211 million licensed drivers, and over 125 million automobiles registered in 2011, this admittedly vague estimate seems fair. See *supra* note 118 for an estimate of driver's license holders. See *State Motor-Vehicle Registrations - 2011*, FED. HIGHWAY ADMIN. (2012), <http://www.fhwa.dot.gov/policyinformation/statistics/2011/pdf/mv1.pdf> (Estimating total number of automobiles (excluding trucks, buses) registered in 2011: 125,656,528, and estimating number of all motor vehicle registrations in 2011 to be 244,778,179).

drivers). The ACA, by contrast, may require roughly six million Americans to purchase insurance or make the Shared Responsibility Payment, a far smaller number.<sup>130</sup> Further, the ACA contains a hardship exemption, as well as other exemptions from the usual Shared Responsibility Payment for not obtaining insurance in the ACA.<sup>131</sup> The large majority of Americans do and will get their health care through employer-provided insurance, Medicare, Medicaid, or the Veterans' Administration.<sup>132</sup>

Second, state auto insurance mandates are enforced with a wide range of penalties, including stiff fines and criminal punishment for those who drive without insurance in some states.<sup>133</sup> Penalties differ from state to state but ten states punish first time offenders with jail time, while twenty states impose a fine.<sup>134</sup> Upon a second infraction, penalties can increase

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<sup>130</sup> See *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act*, CONG. BUDGET OFFICE (Apr. 30, 2010), [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/individual\\_mandate\\_penalties-04-30.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/individual_mandate_penalties-04-30.pdf) (the majority of the uninsured population will not be subject to the penalty; estimating about 4 million people will be subject to the penalty); Linda J. Blumberg, Matthew Buettgens, & Judy Feder, *The Individual Mandate in Perspective*, URBAN INST. 1-2 (Mar. 2012), <http://www.urban.org/UploadedPDF/412533-the-individual-mandate.pdf>.

<sup>131</sup> Professor Mark Hall explains,

“[t]echnically, the mandate applies to all legal residents who are not in prison and who do not claim a religious exemption, but several categories of people are exempt from paying the penalty for noncompliance. PPACA § 1501(b), 26 U.S.C.A. § 5000A(d)-(e) (West Supp. 1A 2010). Exemptions include people whose income is below the tax-filing threshold and people who cannot afford coverage, which is defined as the lowest-priced individual insurance plan costing them more than 8% of their household income. *Id.*, 26 U.S.C.A. § 5000A(e)(1)-(2). Exemptions also extend to members of Indian tribes, to individuals with gaps in coverage of three months or fewer, and to those suffering general hardship as defined by the Department of Health and Human Services. *Id.*, 26 U.S.C.A. § 5000A(e)(3)-(5).”

Hall, *supra* note 44, at 1830 n.20.

<sup>132</sup> Blumberg, Buettgens, & Feder, *supra* note 130. 60% of Americans obtain health insurance through their own or a family member's employer. ABRAHAM & SCHWARCZ, *supra* note 29, at 4.

<sup>133</sup> See *infra* notes 134-35.

<sup>134</sup> Jail time for first time offenders: Alabama: ALA. CODE. § 32-7A-12 (2012) (imposing not more than 3 months in jail); Kentucky: KY. REV. STAT. ANN. §

dramatically.<sup>135</sup> The ACA, by contrast, as noted above, is enforceable only by the limited Shared Responsibility Payment, generally “far less” than the

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187.990 (West 2012) (imposing 90 days in jail); Massachusetts: MASS. GEN. LAWS ANN. ch. 90, § 34J (West 2009) (imposing up to one year in jail); Minnesota: MINN. STAT. ANN. § 169.791 (2003) (imposing 90 days in jail); New York: N.Y. VEH. & TRAF. LAW. § 319 (McKinney 2003) (imposing a fine of \$150-1,500, a civil penalty fine of \$750 and/or 15 days in jail); Oklahoma: OKLA. STAT. tit. 47, § 7-606 (2011) (imposing up to 30 days in jail); South Carolina: S.C. CODE ANN. § 56-9-80 (2011) (imposing up to 30 days in jail); South Dakota: S.D. CODIFIED LAWS § 32-35-113 (2012) (imposing a \$500 fine or up to 30 days in jail); West Virginia: W. VA. CODE ANN. § 17D-2A-9 (2012) (imposing a \$200-5,000 fine and/or up to 15 days in jail); Wyoming: WYO. STAT. ANN. § 31-4-103 (West 2010) (imposing a \$250-700 fine and/or up to six months in jail). Fines for first time offenders: *See* Alabama: ALA. CODE § 32-7A-16 (2000) (Class C Misdemeanor resulting in a fine of not more than \$500); Arizona: ARIZ. REV. STAT. ANN. § 28-4135 (2009) (issuing a \$500 fine); Colorado: COLO. REV. STAT. ANN. § 42-4-1409 (West 2010) (issuing a fine of \$500); Delaware: DEL. CODE ANN. tit. 21 § 2118(s)(1) (West 1995) (issuing a fine from \$1,500-2,000); District of Columbia: D.C. CODE § 31-2413(b)(1)(A) (2011) (issuing a civil fine of \$500); Hawaii: HAW. REV. STAT. § 431:10C-117 (2006) (issuing a \$500 fine); Illinois: 625 ILL. COMP. STAT. ANN. § 5/3-707 (West 2010) (issuing a \$500-1000 fine); Iowa: IOWA CODE ANN. § 321A.32 (West 1997) (issuing a \$250-1,500 fine); Kentucky: KY. REV. STAT. ANN. § 187.990 (West 2012) (issuing a \$500 fine, 30 days imprisonment, or both); Massachusetts: MASS. GEN. LAWS ANN. ch. 90, § 34J (West 2009) (issuing a \$500-5,000 fine and/or up to 1 year in prison); Minnesota: MINN. STAT. ANN. § 169.791 (West 2011) (issuing a \$200-1,000 fine); Mississippi: MISS. CODE ANN. § 63-15-4 (West 2010) (issuing a \$500 fee); Nebraska: NEB. REV. STAT. ANN. § 60-3,168 (West 2005) (issuing a fine of \$100-500); Nevada: NEV. REV. STAT. ANN. § 485.187 (West 2001) (issuing a fine of \$600-1,000); New Jersey: N.J. STAT. ANN. § 39:6B-2 (West 2011) (issuing a \$300-1,000 fine); New York: N.Y. VEH. & TRAF. § 319 (McKinney 2003) (issuing a \$150-1,500 fine); South Dakota: S.D. CODIFIED LAWS § 32-35-113 (2003) (issuing a \$500 fine or thirty days imprisonment); Vermont: VT. STAT. ANN. tit. 23, § 800 (West 2000) (issuing a civil penalty of \$250-500); West Virginia: W. VA. CODE § 17d-2a-7 (West 2011) (issuing a \$200-5,000 fine and/or up to 15 days imprisonment); Wisconsin: WIS. STAT. ANN. § 344.65 (West 2009) (issuing a \$500 fine); Wyoming: WYO. STAT. ANN. § 31-4-103 (West 2006) (issuing a \$250-750 fine and/or 15 days imprisonment).

<sup>135</sup> For example, Arizona requires two-time offenders to pay \$750 and forgo their driving privileges for six months; a third violation increases the fine up to \$1,000. *See* ARIZ. REV. STAT. ANN. § 28-4135 (2012). Arkansas imposes second time offenders \$250-500 and fines subsequent offenders \$500-1,000 and/or imposes a sentence of one year in jail. ARK. CODE ANN. § 27-22-103 (West 2011). Colorado and Utah penalize second-time offenders with a \$1,000 fine. COLO. REV.

cost of insurance for those who can afford to buy but refuse to purchase insurance.<sup>136</sup> There are no other penalties.<sup>137</sup> The ACA individual mandate is significantly less coercive than auto insurance mandates.

#### D. CONCLUSION

A common response to the example of car insurance mandates as a relevant precedent, that driving is a choice so that auto insurance mandates are irrelevant, falls apart under scrutiny. Driving is not a pure choice, the ACA mandate creates a choice, and auto insurance mandates actually are far more coercive than the ACA mandate. Dismantling the “choice rejoinder” reinforces the point that auto insurance mandates are relevant precedents for the ACA. The next section describes how today’s system of auto insurance mandates labored under strikingly similar political and legal challenges for decades before becoming the well-settled arrangement that it is today.

#### IV. THE FORGOTTEN HISTORY OF AUTO INSURANCE MANDATES

This section traces the forgotten history of development of auto insurance mandates, highlighting two aspects that are relevant to the ACA

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STAT. ANN. § 42-4-1409 (West 2010); UTAH CODE ANN. § 41-12a-302 (West 2007). Idaho imposes a \$1,000 fine and/or up to 6 months in jail. IDAHO CODE ANN. § 49-1232(2) (West 2012). The District of Columbia increases its initial civil penalty of \$500 by 50% for each additional offense, D.C. CODE § 31-2413(b)(1)(A) (2011), while Hawaii fines two-time offenders three times as much (\$1,500) for their second offense. HAW. REV. STAT. § 431:10C-117 (West 2006). In Kansas, second-time offenders must pay \$800-2,500, KAN. STAT. ANN. § 40-3104(g)(2) (West 2010). Minnesotans, who for the second time violate their compulsory auto insurance mandates, must pay up to \$3,000. MINN. STAT. ANN. § 169.791 (West 2011). New Jersey also imposes a stark punishment for repeat time offenders; they must pay up to a \$500 fine, spend up to 14 days in jail, and complete thirty days of community service. N.J. STAT. ANN. § 39:6B-2 (West 2011). Moreover, Wyoming imposes an even greater fine (\$500-1,500) and sentences these violators up to six months in jail. WYO. STAT. ANN. § 31-4-103 (2006).

<sup>136</sup> *NFIB v. Sebelius*, 132 S. Ct. 2566, 2597 (2012).

<sup>137</sup> As Justice Roberts stated, “[n]either the [ACA] nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS.” *Id.*



mandate.<sup>138</sup> First is the complex legislative evolution of mandates which showcases both the public-private nature of how U.S. society handles the risks of automobiles and the contingent nature of arguments about freedom in the context of insurance mandates. Second is the constitutional history of auto insurance mandates; in this history, the public welfare dimensions of insurance easily have trumped claims that mandates unconstitutionally interfere with freedom.

A. THE COMPLEX LEGISLATIVE EVOLUTION OF MANDATES

The spread of automobiles was an essential backdrop to the development of auto insurance mandates. The rapid growth in the number of vehicles on U.S. roads—the number of cars increased by ten times between 1915 and 1930—led to huge changes in the U.S.<sup>139</sup> The very welcome explosion in mobility went along with tremendous increases in injuries in the first half of the twentieth century.<sup>140</sup> Injuries were far more common on a per-mile basis than they are now, and health and disability insurance was far less common, so that injuries were likely to cause disastrous financial consequences in addition to whatever physical and emotional injuries they caused.<sup>141</sup> Legislative intervention was needed, and various approaches were tried to deal with the problems caused by autos.<sup>142</sup> In 1927, Massachusetts became the first state to adopt a compulsory liability insurance plan.<sup>143</sup> Its major purpose was to ensure that defendants

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<sup>138</sup> Space limitations preclude a comprehensive history of the development of auto insurance mandates. *See generally* LIABILITY, *supra* note 54, at 70-82; Jerry & Richmond, *supra* note 26, § 131; Engstrom, *supra* note 89; Simon, *supra* note 27.

<sup>139</sup> LIABILITY, *supra* note 54, at 70.

<sup>140</sup> Simon, *supra* note 27, at 540.

<sup>141</sup> LIABILITY, *supra* note 54, at 72-73.

<sup>142</sup> Most states began by passing "financial responsibility" laws, which required drivers involved in an accident caused by their negligence to show that they had sufficient means to pay future claims. Connecticut passed the first such law, in 1925, and 18 states passed similar laws by 1932. LIABILITY, *supra* note 54, at 72. Many drivers satisfied these requirements by buying liability insurance. *Id.* at 72. But these laws did not do anything to make sure that victims of a driver's first negligently-caused accident would be compensated. *Id.* at 73.

<sup>143</sup> *See* LIABILITY, *supra* note 54, at 73; WOODRUFF, FONSECA & SQUILLANTE, *supra* note 71, § 3:21, at 90. The plan required drivers to show their ability to cover damage caused by an accident in advance, unlike other states' financial responsibility laws. LIABILITY, *supra* note 54, at 72-73. The plan allowed drivers to make a cash deposit in advance as an alternative, *In re* Opinion of the Justices, 147

were solvent.<sup>144</sup> The road to our nationwide web of auto insurance mandates, which now includes high-risk plans in all states, liability insurance in virtually all states, uninsured motorist coverage in twenty-two states, and some combination of Med-Pay coverage, underinsured motorist coverage, and no-fault elements in many states, was not smooth, quick, or inevitable.

The auto insurance industry opposed insurance mandates for more than six decades after the first-in-the-nation 1927 Massachusetts law took effect.<sup>145</sup> A major concern was that, although liability insurance mandates obviously increase the demand for insurance, the mandates would force companies to cover high risk drivers and reduce profitability.<sup>146</sup> In Massachusetts, the initial experience after compulsory liability insurance passed was lowered profits, which stalled the momentum of those favoring compulsory insurance and strengthened industry opposition.<sup>147</sup> Industry representatives used arguments based on freedom and American values to oppose mandates.<sup>148</sup>

The opposition to mandates was articulated in terms of freedom and free enterprise.<sup>149</sup> For example, C.D. McVay, an insurance company president, wrote in 1954 that mandates raised “the entire question of the validity of private enterprise.”<sup>150</sup> He doubted the need for such mandates when the number of deaths from auto accidents over a nine-year period was less than the number of deaths from household accidents in Ohio over the same period, and questioned the legislative priority accorded to auto

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N.E. 681 (Mass. 1925), but is generally referred to as “compulsory liability insurance legislation.” *LIABILITY*, *supra* note 54, at 73.

<sup>144</sup> *JERRY & RICHMOND*, *supra* note 26, § 131, at 920.

<sup>145</sup> *LIABILITY*, *supra* note 54, at 73. As Calvin Brainard wrote in his 1961 book, “[p]erhaps no other legislation has been so often proposed over so many years and so strenuously opposed as that of compulsory auto insurance.” *BRAINARD*, *supra* note 71, at 428.

<sup>146</sup> *LIABILITY*, *supra* note 54, at 74.

<sup>147</sup> *Id.*

<sup>148</sup> *See infra* notes 149-153, 163, 165, and accompanying text.

<sup>149</sup> *See, e.g.,* C.D. McVay, *The Case Against Compulsory Automobile Insurance*, 15 OHIO ST. L. J. 150, 154 (1954). Calvin Brainard reports in a 1961 book that a member of the Casualty Actuarial Society told a meeting of the National Association of Casualty and Surety Executives: “The threat of compulsory automobile insurance is not dead. The present danger in the situation is that we may become weary of the battle and so let ourselves be beguiled into believing that compulsory automobile insurance is not the evil which in our hearts we know it to be.” *BRAINARD*, *supra* note 71, at 435.

<sup>150</sup> McVay, *supra* note 149, at 154.

accident injuries: “[i]f we are going to set out a program of compensation for loss from accident there is no logic or justification based on the social, economic theory in not including any and all forms of accidental injury and death.”<sup>151</sup> Coming as it did in 1954, and tying mandates to “social, economic theory” and the elimination of private enterprise, he may have been referring to the threat of socialism, although he does not say so explicitly.<sup>152</sup> Regardless of whether he was referring to socialism, he is saying that mandates directly threaten freedom and capitalism since they may lead to creating an overly controlling and protective society where all risks are insured.<sup>153</sup>

After Massachusetts’ pioneering 1927 law and the intervening Depression, it was not until the 1950s that a second state, New York, passed a mandatory liability insurance law.<sup>154</sup> During the 1930s, a proposal for a mandatory auto insurance plan modeled on workers compensation with a no-fault theory of compensation was developed by an expert commission.<sup>155</sup> It was opposed by insurance companies and did not pass in any state.<sup>156</sup> Reform efforts in the 1970s to change from a negligence system to a no-fault system stalled after initial successes and have not fundamentally changed the system.<sup>157</sup>

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<sup>151</sup> *Id.*

<sup>152</sup> Tellingly, Calvin Brainard wrote in 1954, “[C]ritics of universal financial responsibility through statutory compulsion fear that it will ‘lead to among other things: administrative problems, more accidents, fraudulent claims, higher claims costs, less insurance protection for the public, politics in rate making, the end of the private insurance industry, and socialism.’” BRAINARD, *supra* note 71, at 435. *See also supra* note 27.

<sup>153</sup> Calvin Brainard quotes the Secretary of the Treasury, Mr. Robert B. Anderson, as stating in 1959 that the strength of the American way of life is grounded in “reliance on the integrity, wisdom and initiative of the individual—not the directives of an all-wise government” in a speech to the annual convention of the National Association of Life Underwriters. BRAINARD, *supra* note 71, at 206. Brainard goes on to state “compulsory insurance programs are at odds to a greater or less extent with this statement of principle wherever individuals have it within their means to obtain minimum protection voluntarily.” *Id.* at 206.

<sup>154</sup> WIDISS & THOMAS, *supra* note 74, §1.10, at 9.

<sup>155</sup> LIABILITY, *supra* note 54, at 74. This was known as “The Columbia Plan”, and was favored by many of those considered to be “the best minds” in the field. *Id.* *See generally* Simon, *supra* note 27.

<sup>156</sup> Economic problems such as the Depression eclipsed the importance of the issue. LIABILITY, *supra* note 54, at 75-76.

<sup>157</sup> *See generally* LIABILITY, *supra* note 54, at 75-76; Engstrom, *supra* note 89.

In 1956, New York became the second state to pass a mandatory liability insurance law; other states gradually followed New York's example and by 1980, auto liability insurance was mandatory in most states, despite continuing insurance company opposition.<sup>158</sup>

While opposing mandates, the insurance industry developed auto insurance products such as uninsured motorist coverage to fill social needs, cover risk privately, and stave off governmental control.<sup>159</sup> Such products initially were optional but many states gradually mandated them.<sup>160</sup> As states developed legislation requiring drivers to have insurance, the problem arose that many drivers were considered by insurance companies to be too risky to insure. High-risk plans were gradually passed in every state so that companies were mandated to cover a share of drivers they thought were too risky to insure.<sup>161</sup> These plans were at times proposed by the insurance industry as a way to avoid government takeover of the risk, and at times were opposed by insurance companies as a violation of their

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<sup>158</sup> See *LIABILITY*, *supra* note 54, at 82.

<sup>159</sup> The invention of uninsured motorist coverage by insurance companies exemplifies this dynamic. Uninsured motorist coverage requires drivers to buy coverage to protect themselves against the risk that they will be injured by an uninsured or hit-and-run motorist. *WIDISS & THOMAS*, *supra* note 74, §1.2, at 2. The problem of uncompensated auto injuries continued to be urgent and acute after World War II, when auto use and auto accidents rapidly increased. *Id.* Legislative pressure, especially in New York, increased for liability insurance mandates. Insurance company opposition to liability insurance mandates and other changes in insurance regulation remained firm. *Id.* §§ 1.8, 1.14, at 7, 14. Faced with a stalemate, the New York Superintendent of Insurance asked insurance companies for a solution that did not involve mandates, and the insurance industry in response invented the idea of uninsured motorist coverage. *Id.*, § 1.8, at 8. The coverage would protect the driver by putting the driver in the same position she would have been in, had the motorist who caused her injury actually carried the required insurance. *Id.* The coverage also would protect others who were "insureds" on the policy, such as passengers. *Id.* Initially uninsured motorist coverage was optional but gradually became mandatory in 21 states and the District of Columbia. See, e.g., *Nat'l Fed'n of Indep. Businesses v. Sibelius*, 132 S. Ct. 2566, 2612 (2012). In the states where its purchase is not mandatory, companies nonetheless are required to offer it even though they might prefer not to. *WIDISS & THOMAS*, *supra* note 74, §§1.1, 1.11, 1.14, at 2, 10, 15 (noting that uninsured motorist coverage is now the subject of mandates in 49 states; mandates require either an uninsured motorist coverage in every policy or that such a policy be offered to all insurance buyers).

<sup>160</sup> *WIDISS & THOMAS*, *supra* note 74, § 1.9, at 8; *ROBINETTE*, *supra* note 74.

<sup>161</sup> See *supra* note 112 (explaining how every state has a high risk plan).

freedom of contract.<sup>162</sup> Cars were so central that even risky drivers must have the opportunity to buy insurance to drive, legislatures concluded.<sup>163</sup>

Insurance companies continued to oppose insurance mandates even until the late 1980s.<sup>164</sup> Congress held hearings on auto insurance in 1988, and at those hearings, a representative of the American Insurance Association testified that the automobile insurance industry opposed mandates “because we believe them fundamentally anathema to American values.”<sup>165</sup> The insurance association representative did not specify the values to which he referred, but it seems likely that freedom of choice and free enterprise would be among the values to which he was alluding. The industry spokesman also blamed mandatory insurance for problems in the insurance industry at that time and argued for repealing or reducing the mandates.<sup>166</sup>

By 2011, auto insurance for drivers’ liability was mandatory in all but one jurisdiction, and states had a variety of other auto insurance mandates.<sup>167</sup> Private insurance companies have adjusted to the auto insurance mandates, and there is now a thriving and very competitive market for auto insurance in the United States.<sup>168</sup> This market continues to innovate, as evidenced by the concept and technology of pay-as-you-

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<sup>162</sup> See *Cal. State Auto. Ass’n Inter-Ins. Bureau v. Maloney*, 341 U.S. 105, 108 (1941). This constitutional challenge to California’s high risk plan reached the Supreme Court. See *infra* Part III.B.

<sup>163</sup> In the development of assigned risk plans, we also see the universal recognition that the auto insurance market, left to its own devices, will produce an unacceptably high number of people considered uninsurable. See *Cal. State Auto. Ass’n Inter-Ins. Bureau*, 341 U.S. at 106-07.

<sup>164</sup> See, e.g., *Hearing Before the Subcomm. on Commerce, Consumer Protection, and Competitiveness of the Comm. on Energy and Commerce H. of Rep.*, 100th Cong. 325 (1988) (statement of David Snyder, Am. Ins. Ass’n).

<sup>165</sup> *Id.* at 325.

<sup>166</sup> Snyder, representing the American Insurance Association, claimed “Auto insurance problems result from legal requirements to buy automobile insurance, unrealistically high mandatory coverages, skyrocketing losses resulting from lawsuits, health care costs, crime and fraud, auto repair costs, preventable deaths and injuries on our highways, and counter-productive regulatory intervention into the private sector.” *Id.* at 323. He argued for the repeal or reduction of mandatory insurance and financial responsibility requirements. *Id.* at 324.

<sup>167</sup> See *supra* Part I.C. *Compulsory Auto/Uninsured Motorists*, INS. INFO. INST. (Feb. 2013), [http://www.iii.org/issues\\_updates/compulsory-auto-uninsured-motorists.html](http://www.iii.org/issues_updates/compulsory-auto-uninsured-motorists.html).

<sup>168</sup> See *supra* note 91.

drive.<sup>169</sup> Insurance companies have long urged more federal governmental efforts to promote safety,<sup>170</sup> and also have independent safety promotion programs.<sup>171</sup> Price competition for customers is fierce, particularly with the advent of internet commerce.<sup>172</sup> Driving has become an essential part of U.S. life, the U.S. economy, and how millions of Americans get to work, school, medical care, and shopping. Although often overlooked, auto insurance mandates are an important part of this picture.<sup>173</sup> Now the Insurance Information Institute, an influential national industry group, states that “[t]he public generally supports compulsory insurance and wants these laws enforced.”<sup>174</sup> Auto insurance laws exemplify how government mandates coupled with private competition have resulted in a successful system which extends coverage and shares risk very broadly, bringing many benefits to consumers.<sup>175</sup>

The twentieth-century freedom and free enterprise arguments against auto insurance mandates are no longer made by the insurance

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<sup>169</sup> Progressive Insurance Company, for example, has a program known as Snapshot, which promises to save good drivers up to 30% with use of a device that is plugged into drivers’ cars and transmits information such as how and when one drives which is used to revise drivers’ rates on a monthly basis. *See How Snapshot Works*, PROGRESSIVE.COM, [www.progressive.com/auto/snapshot-how-it-works.aspx](http://www.progressive.com/auto/snapshot-how-it-works.aspx) (last visited Feb. 27, 2013). *See generally* Wriggins, *supra* note 65 (detailing pay-as-you-drive auto insurance innovations and arguing such insurance would reduce driving). Insurance companies have developed partnerships with private environmental groups such as the Hartford’s partnership with the Sierra Club, through which Hartford offers lower rates on hybrid vehicles. Matthew Sturdevant, *The Hartford Announces New Affiliation With Sierra Club*, COURANT.COM (June 2, 2011, 2:13 PM) [http://blogs.courant.com/connecticut\\_insurance/2011/06/the-hartford-announces-new-aff.html](http://blogs.courant.com/connecticut_insurance/2011/06/the-hartford-announces-new-aff.html).

<sup>170</sup> *See, e.g., Hearing Before the Subcomm. on Commerce, Consumer Protection, and Competitiveness of the Comm. on Energy and Commerce H. of Rep., supra* note 164, at 324.

<sup>171</sup> Allstate Insurance Company and the affiliated Allstate Foundation have made research on teens and risk, and teen driver safety, a priority. *See, e.g., Chronic, A Report on the State of Teen Driving 2005* (Allstate Found., Northbrook, IL), 2005, available at <http://www.allstate.com/content/refresh-attachments/citizenship/chronic.pdf>.

<sup>172</sup> *See supra* note 91.

<sup>173</sup> *See* LIABILITY, *supra* note 54, at 101-103; DISTRIBUTING RISK, *supra* note 65, at 219.

<sup>174</sup> INS. INFO. INST., *supra* note 167.

<sup>175</sup> *See supra* notes 167-173 and accompanying text.

industry and seem to have very little traction for most people today. As insurance expert Kenneth Abraham observes:

For most people, paying sizable sums for auto insurance has simply become part of the background cost of living. The whole insurance and liability system for dealing with auto accidents has become so embedded in our lives that it is almost transparent.<sup>176</sup>

While most people probably do not think about auto insurance mandates much, and do not seem to understand the specifics of mandates well,<sup>177</sup> there is a broad recognition on the part of both insurance companies and people that auto insurance mandates are one of the ways we deal as a society with the risks of driving.<sup>178</sup>

#### B. QUESTIONS OF CONSTITUTIONALITY

The legality of the various kinds of auto insurance mandates is now well-established. However, when they passed their constitutionality was doubted and at times challenged. Decisions generally upheld them.<sup>179</sup> The court decisions that, almost without exception, upheld them over the last 87 years showcase the public welfare function of insurance.

Prior to passing its pioneering 1927 auto insurance mandate, the Massachusetts legislature asked for an Advisory Opinion from the Supreme Judicial Court of that state on twenty-nine questions concerning its constitutionality.<sup>180</sup> The Supreme Judicial Court pronounced the law constitutional.<sup>181</sup> The Court found that the dangers posed by cars presented ample reason for requiring drivers to prove that they could cover tort judgments, since “legal liability without financial responsibility is a barren right to one who sustains injury by the wrongful act of another.”<sup>182</sup> The

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<sup>176</sup> LIABILITY, *supra* note 54, at 102.

<sup>177</sup> *See supra* note 12.

<sup>178</sup> *See* INS. INFO. INST., *supra* note 167.

<sup>179</sup> *See infra* note 206.

<sup>180</sup> *In re Op. of the Justices*, 147 N.E. 681 (Mass. 1925). The legislature asked ten questions, several of which had many subsections, leading to a total of 29. The questions ranged from whether the law’s requirements for operators were constitutional to whether the regulation of policies (such as not allowing termination during the term of the policy) were constitutional. *Id.* at 684-686.

<sup>181</sup> *See id.* at 693.

<sup>182</sup> *Id.* at 694.

court stressed the “peculiar nature” of insurance, which subjects it to broad government regulation since it “affects large numbers of people and is intimately connected with the public welfare.”<sup>183</sup> The court noted that compulsory workers compensation insurance had been upheld against due process challenges, and opined that workers compensation mandates were “a greater stretch of legislative power than is contemplated by the proposed bill.”<sup>184</sup> The court upheld rules against cancellations and limitations on underwriting in the legislation, noting that the law’s interference with companies’ “freedom of contract” and its interference with drivers’ “freedom of action” were both justified.<sup>185</sup> Judicial review of insurance company decisions was necessary because the refusal to issue a policy “may drive one out of business or seriously hamper his convenience.”<sup>186</sup> As a result of that 1925 opinion, the law’s constitutionality has rarely been challenged; the thorough Massachusetts opinion set the stage for acceptance of other states’ mandates.<sup>187</sup>

In 1933, the U.S. Supreme Court faced the question of whether the compulsory auto liability insurance law in Massachusetts violated an individual’s fourteenth amendment rights.<sup>188</sup> Mr. Joseph Poresky, pro se, claimed that “he cannot comply with the statute” although he did not say why, and asserted that the statute violated his Fourteenth Amendment rights.<sup>189</sup> He sought a writ of mandamus forcing the federal court in Massachusetts to hear his application for an injunction, but the Supreme Court simply denied the petition, citing the 1925 Massachusetts Advisory

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<sup>183</sup> *Id.* at 698.

<sup>184</sup> *Id.* at 696. Workers compensation legislation began to be passed in the United States in the early twentieth century. Laws were broadly modeled on Britain’s and Germany’s laws which were passed in the late nineteenth century. 1 LARSON, *supra* note 84 at §2.06 at 2-10. *See generally* SKOCPOL, *supra* note 27, at 285-302; WITT, *supra* note 84. Constitutional challenges were filed to workers compensation statutes but they were ultimately upheld by the Supreme Court in *Mountain Timber Co. v. Washington*, 243 U.S. 219 (1917). *See supra* note 84.

<sup>185</sup> *See In re Op. of the Justices*, 147 N.E. at 701.

<sup>186</sup> *Id.*

<sup>187</sup> WOODRUFF, FONSECA & SQUILLANTE, *supra* note 71, §3:29, at 95.

<sup>188</sup> *Ex Parte Poresky*, 290 U.S. 30, *reh’g. denied*, 366 U.S. 922 (1933). Although the decision does not specifically mention due process, it has been referred to as pertaining to due process rights. WOODRUFF, FONSECA & SQUILLANTE, *supra* note 71, §3:29, at 95.

<sup>189</sup> *Ex Parte Poresky*, 290 U.S. 30, *reh’g. denied*, 366 U.S. 922 (1933).



Opinion of the Justices and other cases supporting government's authority to enact laws in the interest of the public safety and welfare.<sup>190</sup>

The most high-profile constitutional challenge was to California's high-risk plan; *California State Auto Association Inter-Insurance Bureau v. Maloney* was decided in 1951 by the United States Supreme Court.<sup>191</sup> The context was that as states gradually passed requirements that drivers have insurance or show that they could pay for harm they caused by some other means, many drivers were considered "high risk" by insurance companies who refused to insure them.<sup>192</sup> States then began passing laws requiring insurance companies to cover a share of high-risk drivers starting in 1938; these plans often are known as assigned risk plans.<sup>193</sup> A California insurance organization<sup>194</sup> challenged the constitutionality of that state's assigned risk plan, passed in 1947, claiming that the law interfered with its due process rights by requiring it to contract with people it did not want to contract with, thereby making it less profitable.<sup>195</sup> The challenge resulted in

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<sup>190</sup> *Id.*

<sup>191</sup> See Cal. State Auto Ass'n Inter-Ins. Bureau v. Maloney, 341 U.S. 105, 107 (1951).

<sup>192</sup> See *supra* notes 113-117 and accompanying text.

<sup>193</sup> JERRY & RICHMOND, *supra* note 26 at §22[e]. Every state has such a plan. See *supra* note 112. New Hampshire enacted the first assigned risk plan in 1938. Snyder, *supra* note 54, at 324. New Hampshire had passed a law in 1937 requiring motorists to deposit security or purchase insurance in a sufficient amount to pay for a lawsuit stemming from a car accident. This type of law is known as a 'financial security law'. See LIABILITY *supra* note 54, at 72. These types of laws were precursors to the current mandatory liability laws; most drivers complied with these laws by purchasing auto liability insurance. *Id.* at 72-73. Many people were unable to deposit the necessary security because they did not have the funds, and were unable to obtain insurance because they were considered too risky for insurers. *Id.* Hence the structure was created where insurers were assigned policyholders they simply were required to cover. *Id.*

<sup>194</sup> The opinion describes the organization, California State Automobile Association Inter-Insurance Bureau, as follows:

Appellant is an unincorporated association which the California District Court of Appeal analogizes to a mutual insurance corporation. The details of its organization and operation are not important here. It is supervised by the Insurance Commissioner of California, like other insurance companies doing a liability insurance business. It was formed to write automobile insurance to a select group of members at a lower cost than the then prevailing rate.

341 U.S. at 106.

<sup>195</sup> *Id.* at 107.

a unanimous 1951 United States Supreme Court opinion that explained the history of assigned risk plans and upheld the California plan.<sup>196</sup> The mandate was on insurers rather than drivers so it is distinguishable. But the case is significant here for several reasons. First, the mandate on companies relates directly to individual mandates since it arose from and was necessitated by these mandates. The case also highlights the deferential treatment given to insurance laws in light of the strong links between insurance, the public welfare, and government regulation, shows how driving has long been a necessity; and illustrates the public-private nature of legislative solutions to thorny public policy problems.

Justice Douglas, writing for the court, first described the California law which required that all drivers show proof of financial responsibility before they could get a driver's license.<sup>197</sup> Justice Douglas stated that the law made it impossible for many people to drive since they were classified as poor risks, rightly or wrongly, by insurance companies and did not have the funds to show proof of financial responsibility with cash as the law allowed.<sup>198</sup> Douglas noted that "many hardship cases developed among people who were dependent upon the use of the highways for a living."<sup>199</sup> One proposed solution was that the state itself would insure these risks.<sup>200</sup> Instead, insurance companies responded with legislation, which the legislature passed, authorizing the Insurance Commissioner to establish a plan for each company to insure some of the drivers who could not obtain insurance in the regular market.<sup>201</sup> The resulting plan assigned higher risk drivers to companies in proportion to their market share.<sup>202</sup>

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<sup>196</sup> *Id.* at 105.

<sup>197</sup> *Id.* at 106. Justice Black believed it was frivolous to suggest there was a constitutional question. *Id.* at 111 ("Mr. Justice Black would dismiss the appeal on the ground that the constitutional questions are frivolous."). At the time of the Maloney case, California did not have mandatory liability insurance for drivers; Massachusetts was still the only state with mandatory liability insurance. See *supra* text accompanying note 158.

<sup>198</sup> *Maloney*, 341 U.S. at 107. The lower court noted concerns that insurance companies' risk classification was inaccurate towards racial minorities, as well as the elderly and young drivers, and caused "much hardship and many inequities." *Cal. State Auto Ass'n Inter-Ins. Bureau v. Downey*, 216 P.2d 882 (Cal. App. 1st Dist.) (1950), *aff'd*, *Cal. State Auto. Ass'n Inter-Ins. Bureau v. Maloney*, 341 U.S. 105, 107 (1951).

<sup>199</sup> *Maloney*, 341 U.S. at 107.

<sup>200</sup> *Id.*

<sup>201</sup> *Id.*

<sup>202</sup> *Id.*

The Supreme Court, noting that the state could have taken over the whole field, and that insurance was “a business to which the government has long had a special relation,” upheld the plan as permissible regulation of a challenging problem.<sup>203</sup> Notable was the court’s recognition of the centrality of automobiles, even in 1951, to many people’s livelihoods, and the hardship of not being able to drive.<sup>204</sup> Also striking was the fact that “the economic burden on the public purse” caused by uncompensated injuries was a reason offered for the mandate.<sup>205</sup> Finally, it is noteworthy that high risk plans were developed by private industry in response to the threat of government takeover of insuring for that risk.<sup>206</sup>

State auto insurance mandates of all types have been upheld for decades against constitutional attacks; the “public welfare” nature of insurance, the “special relation” between government and insurance, and the “peculiar nature” of insurance all were factors supporting courts’ acceptance.<sup>207</sup> Legal challenges based on freedom, like the policy

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<sup>203</sup> *Maloney*, 341 U.S. at 109. Justice Douglas wrote that “[c]learing the highways of irresponsible drivers, devising ways and means for making sure that compensation is awarded the innocent victims, and yet managing a scheme which leaves the highways open for the deserving are problems that have taxed the ingenuity of lawmakers and administrators.” *Id.* at 110.

<sup>204</sup> *See Maloney*, 341 U.S. at 107, 110.

<sup>205</sup> Brief for Appellee at 37 n. 23, *Cal. State Auto Ass’n Inter-Ins. Bureau v. Maloney*, 341 U.S. 105 (1951) (No. 310).

<sup>206</sup> *Maloney*, 341 U.S. at 107. The same is true for uninsured motorist coverage, which was also developed to avoid government takeover of the risk. *See supra* note 157.

<sup>207</sup> *Maloney*, 341 U.S. at 110, *In re Op. of the Justices*, 147 N.E. at 698. Cases and advisory opinions deeming auto insurance mandates constitutional include the following: *Drake v. Gordon*, 848 F.2d 701 (6th Cir. 1988). *Bushnell v. Sapp*, 571 P.2d 1100 (Colo. 1977); *Gentile v. Altermatt*, 363 A.2d 1 (Conn. 1975); *Del Rio v. Crake*, 955 P.2d 90 (Haw. 1998); *Washington v. Fireman’s Fund Ins., Co.*, 708 P.2d 129 (Haw. 1985); *Burriss v. N. Assurance Co. of Am.*, 691 P.2d 10 (Kan. 1984); *Manzanares v. Bell*, 522 P.2d 1291 (Kan. 1974); *Fann v. McGuffey*, 534 S.W.2d 770 (Ky. 1975); *Pinnick v. Cleary*, 271 N.E.2d 592 (Mass. 1971); *In re Opinion of Justices*, 147 N.E. 681 (Mass. 1925); *In re Requests of the Governor and the Senate on the Constitutionality of Act No. 294 of the Public Acts of 1972*, 208 N.W.2d 469 (Mich. 1973); *Justices*, 129 A. 117 (N.H. 1925); *Rybeck v. Rybeck*, 358 A.2d 828 (N.J. Super. Ct. App. Div. 1976); *Montgomery v. Daniels*, 340 N.E.2d 444 (N.Y. App. Div. 1971); *Singer v. Sheppard*, 346 A.2d 897 (Pa. 1975); For a comprehensive although dated list of challenges to auto insurance mandates by state *see* IRVIN E. SHERMER, AUTOMOBILE LIABILITY INSURANCE § 11 (Clark Boardman Callaghan, Vol I 1981). *See also* Josephine Y. King,

arguments based on freedom that were made to oppose the laws' passage, have been abandoned. Opponents now use the political process to lobby for changes they seek.<sup>208</sup> The system of auto insurance mandates and private competition has been with us for decades; with constitutional doubts laid to rest and legislative support for the mandates, industry and individuals have adjusted to the very American public-private model of dealing with the consequences of automobile accidents.<sup>209</sup>

## V. CONCLUSION

Now that the Supreme Court has upheld the ACA's individual mandate under the Federal government's taxing power, it is a critical time to look at precedents for the individual mandate, which was not done at the time of the ACA's passage or the Supreme Court case. A systematic examination of auto insurance mandates shows that the ACA individual mandate is not the uniquely coercive anomaly that its opponents claim.

Auto insurance mandates are similar in four important, yet unexamined ways, to the ACA individual mandate. First, both types of mandate are responses to difficult situations that defy simple solutions; there are strong public policy reasons for both types of mandates.

Second, both order people to buy insurance to protect themselves from risks they might want to bear themselves. Third, both require that risks be pooled and spread, which is fundamentally what insurance is and does. Fourth, both mandate that some people buy something from a private

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*Constitutionality of No Fault Jurisprudence*, 1982 UTAH L. REV. 797 (1982); BERNARD P. BELL, 5-46 NEW APPLEMAN LAW OF LIABILITY INSURANCE § 46.03 (Matthew Bender, Rev. Ed. 2011). *But see* Lasky v. State Farm Ins. Co., 296 So.2d 9 (Fla. 1973)(holding that the threshold classifications of the compulsory insurance law were arbitrary); Grace v. Howlett, 283 N.E.2d 474 (Ill. 1972) (Illinois' no-fault law unconstitutionally discriminated against commercial vehicles by limiting their special damages remedies and that the compulsory arbitration provision denied citizens their right to a jury trial); Shavers v. Kelley, - 267 N.W. 2d 72 (Mich. 1978), *cert. denied*, 442 U.S. 934 (1979)(Michigan no-fault law's procedures for rate-setting do not guarantee due process; eighteen months granted for the state to develop a remedy).

<sup>208</sup> People and organizations can and do lobby their representatives to change auto insurance laws if they object to them, as happened in 2011 in Wisconsin. Jason Stein, *Walker Signs Bill Rolling Back Auto Insurance Minimums*, MILWAUKEE WISCONSIN JOURNAL-SENTINEL ONLINE, (Apr. 12, 2011), available at [www.jsonline.com/news/statepolitics/119695019.html](http://www.jsonline.com/news/statepolitics/119695019.html).

<sup>209</sup> LIABILITY, *supra* note 54, at 102-04.

seller; they both use a model of a regulated market combined with private competition to deal with the problems at which they are aimed rather than have a government program handle the problems. Most broadly, they embody essentially the same policy response to a massive public policy problem involving illness or injury and how to pay for needed treatment or redress.

The most common response to the parallel is that auto insurance mandates are distinguishable and actually irrelevant because they are regulating something that is a choice—whereas the ACA mandate coercively intrudes on individuals’ freedom. This “choice rejoinder” resonates with the sentiments underlying the majority’s Commerce Clause discussion, but this Article has shown that it falls apart under scrutiny for three reasons. First, driving is not always a choice, and both caselaw and insurance laws recognize this. The fact that every state has laws requiring insurance companies to insure high-risk drivers shows that driving is seen as a necessity rather than a choice, for example. Second, the Supreme Court’s decision makes clear that the ACA individual mandate presents a choice between buying insurance and paying higher taxes, so it is not coercive in the way opponents claim. Third, car insurance mandates are far more coercive than the ACA mandate in their reach and enforcement mechanisms.

The history of auto insurance mandates, both legislative and constitutional, yields several observations that bear on the ACA. One, arguments about freedom and American values are recycled from generation to generation by reform opponents but do not necessarily have staying power. The current “forced purchase of broccoli”<sup>210</sup> arguments made by mandate opponents and accepted by the majority opinion in the Commerce Clause section may fade over time as the ACA goes into effect. Second, the combination of auto insurance market regulation, including high risk plans that mandate expansion of coverage, with private auto insurance mandates, has been so workable that it is rarely the focus of public attention. The ACA’s individual mandate and other reforms similarly recognize that market intervention is necessary to expand coverage more widely, and envision a system significantly similar to our auto insurance system where insurance companies compete in a regulated market. Third, while constitutional doubts initially were raised about mandates, these doubts have been definitively resolved in part because of what the Massachusetts Supreme Judicial Court called the “peculiar

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<sup>210</sup> See *NFIB v. Sibelius*, 132 S. Ct. 2566, 2591.

nature” of insurance and its significance for the “public welfare”<sup>211</sup> and what the United States Supreme Court called the “special relation” between government and the insurance business.<sup>212</sup> Health insurance has a public welfare function that is far more important than car insurance, so if decisions upholding car insurance showcase the public welfare function of insurance, how much more should the public welfare function of insurance be emphasized in the context of health insurance.

This article has demystified the ACA individual mandate by showing its significant similarities to the commonplace, widely accepted auto insurance mandates found all over the United States. Now that the ACA individual mandate has been shown to be grounded in the U.S. public policy tradition of auto insurance mandates, perhaps the focus can shift to making it work as well as possible.

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<sup>211</sup> *See In re Op. of the Justices*, 147 N.E. at 701.

<sup>212</sup> *Maloney*, 341 U.S. at 105.



# COVERAGE FOR VETERANS WITH POST-TRAUMATIC STRESS DISORDER: A SURVEY THROUGH THE WARS

ANDREA GOMES

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*“No matter how the business of war is adorned by parades, uniforms, and literary glorification of the warrior’s courage, and however it is burdened by administration and logistics, the soldier’s real work is in killing. The soldier’s privilege to kill is unlike anything most other individuals have ever experienced, and the soldier who kills is permanently changed, fixed to the death he has made.”<sup>1</sup>*

*From its first remnants in Ancient Greece, up through the initial wave of “shell shocked” American soldiers in World War I, all the way to its present day status in the midst of the Middle East conflict, Post-Traumatic Stress Disorder (PTSD) is a disease that has continued to evolve, both in its treatments as well as in the societal stigma attached to it. This comment traces the development of PTSD within the context of our nation’s health care treatment and coverage for veterans battling the disorder. The comment documents recent federal legislation which, combined with the ongoing efforts of the Department of Veterans Affairs (DVA), should allow for significant improvements in the treatment and coverage of veterans with PTSD. However, despite the fact that our government has seemingly acknowledged the importance of dealing with the PTSD issue, many veterans are still left without adequate coverage for their mental health care. With troops still returning home from Afghanistan and others just now beginning to see the first signs of PTSD, the Department of Veterans Affairs must strive for even greater health care coverage for its veterans.*

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## I. INTRODUCTION

Since the time of the ancient Greeks, soldiers have encountered significant psychological trauma as a result of experiencing shocking

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<sup>1</sup> ILONA MEAGHER, MOVING A NATION TO CARE 83 (2007) (citing THEODORE NADELSON, TRAINED TO KILL: SOLDIERS AT WAR 37 (2005)).



events during war.<sup>2</sup> The Greek historian Herodotus described an Athenian warrior who, after witnessing the slaughter of a fellow soldier, became “blind” during the Battle of Marathon in 490 B.C. although the soldier was “wounded in no part of his body.”<sup>3</sup> Hundreds of years later, a Swiss physician, Johannes Hofer, would name the illness “nostalgia,” symptoms of which included “melancholy, incessant thinking of home, disturbed sleep or insomnia, weakness, loss of appetite, anxiety, cardiac palpitations, stupor and fever.”<sup>4</sup> During the Napoleonic era, Napoleon’s Chief Surgeon, Dominique Jean Larrey, focused on both biological catalysts and social factors that influenced the illness in prescribing regular exercise, music, and “useful instruction” as the cure for Nostalgia.<sup>5</sup> The disorder has been given names such as “soldier’s heart”, “battle fatigue”, and “shell shock.”<sup>6</sup> Today, however, we call this disease Post-Traumatic Stress Disorder, or PTSD.<sup>7</sup>

Studies conducted since World War II have shown that only two percent of those serving in the military have a “natural-born killer” predisposition.<sup>8</sup> The remaining ninety-eight percent of men must be trained and taught how to pull a trigger to kill.<sup>9</sup> While the military training tactics

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<sup>2</sup> Madeleine Baran, *Timeline: Mental Illness and War Through History*, MINN. PUB. RADIO NEWS (Feb. 2010), <http://minnesota.publicradio.org/projects/2010/02/beyond-deployment/ptsd-timeline/index.shtml>.

<sup>3</sup> MEAGHER, *supra* note 1, at 13.

<sup>4</sup> *Id.* at 14-15 (citing Major Stephane Grenier, *Operational Stress Injuries (OSI): A New Way to Look at an Old Problem*, VETERANS AFF. CAN.: OPERATIONAL STRESS INJ. SOC. SUPPORT (OSISS) PROGRAM, June 12, 2005, [http://www.osiss.ca/pdfs/english/ANewWayToLookAtAnOldProblem\\_March2002\\_e.pdf](http://www.osiss.ca/pdfs/english/ANewWayToLookAtAnOldProblem_March2002_e.pdf)).

<sup>5</sup> MEAGHER, *supra* note 1, at 14 (citing Franklin D. Jones, *Psychiatric Lessons of War*, in *WAR PSYCHIATRY: THE TEXTBOOK OF MILITARY MEDICINE* 6 (Brigadier General Russ Zajtchuk, M.C., U.S. Army ed., 1995)). *See also* Mylea Charvat, Presentation: History of Post-traumatic Stress Disorder in Combat, VETERANS AFF. WAR RELATED ILLNESS & INJ. STUDY CTR., (Sept. 14-15, 2010) *available at* [http://www.warrelatedillness.va.gov/WARRELATEDILLNESS/education/conferences/2010-sept/slides/2010\\_09\\_14\\_CharvatM-History-of-PTSD-in-Combat.ppt](http://www.warrelatedillness.va.gov/WARRELATEDILLNESS/education/conferences/2010-sept/slides/2010_09_14_CharvatM-History-of-PTSD-in-Combat.ppt).

<sup>6</sup> Baran, *supra* note 2.

<sup>7</sup> AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV-TR* 463 (4th ed. 2000) [hereinafter *DSM-IV-TR*].

<sup>8</sup> MEAGHER, *supra* note 1, at 84 (citing CHRIS HEDGES, *WHAT EVERY PERSON SHOULD KNOW ABOUT WAR* 75 (2003)).

<sup>9</sup> MEAGHER, *supra* note 1, at 84.

used to teach American soldiers how to kill are extremely effective,<sup>10</sup> the military does not prepare its soldiers for the long-term psychological trauma they may experience as a result.<sup>11</sup> Thus, the ninety-eight percent without the “natural-born killer” instinct experience trauma regardless of their training and probably do so at a much higher rate than the two percent that needed no conditioning.

Cultures have attempted to treat and rehabilitate veterans for centuries.<sup>12</sup> Different societies throughout history have participated in “cleansing rituals” or “purification rites” for their soldiers in the hopes of allowing for a more seamless transition back into their community.<sup>13</sup> Since its modern inception, government-sponsored treatment and healthcare coverage of these soldiers with PTSD has been a political and controversial issue. The United States’ attempt to care for its soldiers can be traced back to the American Colonies where the English enacted a law in 1636 that provided pensions for injured veterans.<sup>14</sup> In 1812, the Naval Home in Philadelphia was built and was the first national effort to provide medical treatment for disabled soldiers in need.<sup>15</sup>

More recently in the United States, however, insurance coverage in the form of military benefits from the government has become the main source of financial, psychological, and medical support for soldiers and veterans. This support, however, is severely limited. Thousands of soldiers have been unable to secure assistance for their mental health and today, thousands of veterans are still fighting for health care.<sup>16</sup> As a result of this insufficient healthcare coverage, inadequate access to resources, and the

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<sup>10</sup> See *id.* (citing Jeff Tietz, *The Killing Factory*, ROLLING STONE MAG. 54, Apr. 20, 2006, detailing exposé on the U.S. Army’s “Total Control” program which had been used to desensitize its soldiers from the trauma and emotions attached to killing or attacking a human being. “The Army turns out 20,000 infantrymen a year; no other institution in history has trained so many to kill so effectively in such a short time. The number of soldiers who fail to return fire has fallen from seventy-five percent to nearly zero.”).

<sup>11</sup> MEAGHER, *supra* note 1, at 85-86.

<sup>12</sup> *Id.* at 122.

<sup>13</sup> *Id.*

<sup>14</sup> U.S. DEP’T OF VETERANS AFFAIRS: OFFICE OF PUB. & INTERGOVERNMENTAL AFFAIRS, VA HISTORY IN BRIEF 3 (2008), [http://www.va.gov/opa/publications/archives/docs/history\\_in\\_brief.pdf](http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf).

<sup>15</sup> See *id.*

<sup>16</sup> See Melissa Suran, *Veterans Still Fighting – For Health Care*, MEDILL REPORTS WASH. (Aug. 26, 2009), <http://news.medill.northwestern.edu/washington/news.aspx?id=139097>.

stigma that is still associated with mental health illnesses like PTSD, veterans resort to drugs, are unable to secure employment, become homeless, and at times, even resort to violence.<sup>17</sup> Although the number and quality of available resources and funding have certainly increased over the past century,<sup>18</sup> there is still a long way to go to secure the support and coverage veterans need to resume civilian lifestyles.

This comment seeks to address the development of PTSD by examining its presence in the major wars of the twentieth and twenty-first centuries. Society's views concerning each war and the stigma surrounding mental illness in World War I, World War II, Vietnam and the current conflicts in the Middle East affected not only how the returning soldiers manifested the illness itself, but also the ways in which veterans were provided for in terms of mental health care insurance coverage and treatment. By examining and analyzing society's definition of mental health in conjunction with America's sentiments concerning the wars, it will become apparent that PTSD has manifested itself in different ways in each war which, in turn, affected government coverage for PTSD coverage and treatment.

## II. MENTAL HEALTH BACKGROUND

### A. WHAT IS MENTAL DISORDER?

By the year 1840, there were only eight "asylums for the insane" located within the United States.<sup>19</sup> Advocates such as Dorothea Dix spearheaded movements for those with mental illnesses, which, in 1840, resulted in the transfer of the mentally ill from jails and prison-like asylums for the insane to one of the thirty-two new mental hospitals that

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<sup>17</sup> See generally RISDON N. SLATE & W. WESLEY JOHNSON, *THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS & OPPORTUNITY FOR THE JUSTICE SYSTEM* (2008); CTR. FOR MILITARY HEALTH POLICY RESEARCH, RAND CORP., *INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY* (Terri Tanielian & Lisa H. Jaycox eds., 2008) [hereinafter *INVISIBLE WOUNDS OF WAR*].

<sup>18</sup> See DEP'T OF VETERANS AFFAIRS, *VA HISTORY IN BRIEF*, *supra* note 14, at 32-36.

<sup>19</sup> *Important Events in NIMH History*, NAT'L INST. OF MENTAL HEALTH, <http://www.nih.gov/about/almanac/archive/1998/organization/nimh/history.html> (last visited Mar. 1, 2013).

Dix had advocated for.<sup>20</sup> The shift in terminology from “asylums for the insane” to “mental hospitals” is itself indicative of society’s—albeit slowly—increasing understanding of mental health. By 1940, the U.S. Public Health Service finally established what would later be called the Division of Mental Hygiene, in the hopes of merging research on substance abuse and mental diseases.<sup>21</sup> Although steps have certainly been taken in the last century to assist those with mental disorders and to de-stigmatize the world of mental health, the stigma that still exists today negatively affects not only those with mental illnesses but those involved in mental health care as well.<sup>22</sup>

The American Psychiatric Association’s Fourth Revised Edition of the Diagnostic and Statistical Manual of Mental Disorders, or the DSM-IV-TR, defines mental disorder as a

[C]linically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one of more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.<sup>23</sup>

Although the DSM’s definition is certainly instructive in many instances, what actually constitutes a “mental disorder” is still vague at best. The boundaries differentiating mental disorders from physical illness are slowly beginning to erode as we gain more understanding of how the brain and the body are connected to one another. The authors of the DSM-IV-TR state that the separation of the two—physical illnesses and mental disorders—creates a “reductionistic anachronism of mind/body dualism...there is much ‘physical’ in ‘mental’ disorders and much ‘mental’ in ‘physical’ disorders.”<sup>24</sup> The authors further admit that although the definition persists in the most current edition of the DSM, “no definition

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<sup>20</sup> NAT’L INST. OF MENTAL HEALTH, *supra* note 19; *See also* U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 78 (1999).

<sup>21</sup> NAT’L INST. OF MENTAL HEALTH, *supra* note 19; *See also* U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 20.

<sup>22</sup> *See generally* SLATE & JOHNSON, *supra* note 17.

<sup>23</sup> DSM-IV-TR, *supra* note 7, at xxxi.

<sup>24</sup> *Id.* at xxx.

adequately specifies precise boundaries for the concept of ‘mental disorder.’”<sup>25</sup> Not surprisingly, different mental health theories have emerged around the definition of mental disorder which separate mental illness itself into two schools of thought: a biological model, which posits that one’s mental illness is an organic issue found within the physical body, and a behavioral model, which centers its focus on one’s behavior and reaction to environmental stimuli among other behavioral theories.<sup>26</sup>

Today, the distinction between one’s physical health and mental health has been significantly blurred. In 1999, Surgeon General David Satcher published a report on mental health in which he encouraged the American public to abandon the distinction between mental and physical health.<sup>27</sup> As science progresses, the once-separate models of psychology—the biological and the behavioral—have become more intertwined with one another; the biology or physical make-up of the brain is no longer distinct from the way in which one’s environment affects one’s mind.<sup>28</sup>

It is now commonly understood that the way in which people think and experience their lives and the ways in which they exhibit behavior are simply a reflection of the non-stop workings of the brain.<sup>29</sup> Consequently, what our society considers to be “abnormalities” in thought or behavior may simply be a reflection of the abnormalities in the physical make-up of the brain itself.<sup>30</sup> The difficulty in using these scientific advances for the purposes of studying mental illness is the fact that there is often no definite answer; there is usually always a “gray area” between mental health and mental illness.<sup>31</sup>

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<sup>25</sup> *Id.*

<sup>26</sup> CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 7, 10 (5th ed. 2009).

<sup>27</sup> U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 20, at 6.

<sup>28</sup> *Id.* at 31 (“The brain and mind are two sides of the same coin. Mind is not possible without the remarkable physical complexity that is built into the brain, but, in addition, the physical complexity of the brain is useless without the sculpting that environment, experience, and thought itself provides. Thus the brain is now known to be physically shaped by contributions from our genes and our experience, working together. This strengthens the view that mental disorders are both caused and can be treated by biological and experiential processes, working together. This understanding has emerged from the breathtaking progress in modern neuroscience that has begun to integrate knowledge from biological and behavioral sciences.”)

<sup>29</sup> *Id.* at 39.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

## B. POST-TRAUMATIC STRESS DISORDER

Among the many disorders found within the DSM-IV-TR is none other than Post-Traumatic Stress Disorder. Consistently written about throughout history—especially in connection with war-related trauma—but repeatedly redefined, PTSD has affected countless people since its discovery, regardless of the way in which its symptoms appeared or the name the disorder was given. Today, we certainly have a better understanding of the disorder but looking back begs the question: will the illness continue to change as time goes on?

### 1. Diagnosis and Treatment

The DSM-IV-TR defines Post-Traumatic Stress Disorder as the

[D]evelopment of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate...<sup>32</sup>

A person's response to the traumatic event in question must include intense fear, helplessness, or horror.<sup>33</sup> The most common symptoms associated with PTSD include "persistent reexperiencing of the traumatic event...persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness...and persistent symptoms of increased arousal."<sup>34</sup> If the traumatic event was the result of human action, the symptoms may be more severe and may also last longer.<sup>35</sup> Although many veterans may have experienced traumatic events while on duty, not all people who are faced with trauma develop PTSD.<sup>36</sup> Factors that help

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<sup>32</sup> DSM-IV-TR, *supra* note 7 at 463.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Dep't of Veterans Affairs, *Fact Sheet: New Regulations on PTSD Claims*, ¶ 1, VA.GOV (2010), [http://www.va.gov/ptsd\\_qa.pdf](http://www.va.gov/ptsd_qa.pdf).

<sup>36</sup> DEP'T VETERANS AFFAIRS, WHAT IS PTSD? (Jan. 1, 2007), *available at* <http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp>.

determine who may develop the disorder include how long the trauma lasted, if the person lost someone close to them because of the trauma, and how much help and support the person received after the event.<sup>37</sup>

According to the National Center for Posttraumatic Stress Disorder, treatments for PTSD may vary but Cognitive Behavioral Therapy (CBT),<sup>38</sup> Eye Movement Desensitization and Reprocessing (EMDR),<sup>39</sup> and medications called Selective Serotonin Reuptake Inhibitors (SSRIs) are the most effective in treating PTSD.<sup>40</sup> The FDA has approved the use of two SSRIs, Zoloft and Paxil, as the best pharmacological method of treatment for PTSD.<sup>41</sup> Although SSRIs do work, veterans that take such medications may experience symptoms such as a decreased libido, drowsiness and fatigue, and nausea.<sup>42</sup> Dr. Matthew Friedman, a psychiatrist for the National Center for PTSD, encourages veterans who hope to live a life free of medication to pursue psychotherapy.<sup>43</sup> Dr. Friedman clarifies by saying

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<sup>37</sup> *Id.*

<sup>38</sup> NAT'L CTR. FOR POSTTRAUMATIC STRESS DISORDER, UNDERSTANDING PTSD TREATMENT 2, 3 (Feb. 2011), *available at* [www.ptsd.va.gov/public/understanding\\_TX/booklet.pdf](http://www.ptsd.va.gov/public/understanding_TX/booklet.pdf). Included within Cognitive Behavioral Therapy is Cognitive Processing Therapy, or CPT, which consists of four main parts: (1) learning about one's PTSD symptoms and how treatment can help; (2) becoming aware of one's own thoughts and feelings; (3) learning skills to challenge one's thoughts and feelings, also known as "Cognitive Restructuring"; and (4) understanding common changes in beliefs and thoughts that occur after experiencing trauma. *See id.* at 3. Also included within CBT is Prolonged Exposure Therapy, or PE, which also consists of four parts: (1) Education or learning about one's symptoms and how treatment can help; (2) Breathing Retraining to help patient learn how to manage stress; (3) Real World Practice (*in vivo* exposure) to help reduce distress in safe situations that the patient had been avoiding; and (4) Talking through the trauma (imaginal exposure). *See id.*

<sup>39</sup> *Id.* at 5. (EMDR consists of four main parts: (1) Identification of a target memory or image concerning the trauma; (2) Desensitization and reprocessing by focusing on mental images while doing eye movements that therapist has coached patient on; (3) Installing positive thoughts and images once the negative thoughts are no longer distressing; and (4) Body Scanning by focusing on tension or unusual sensations in patient's body in the hope that the patient will be able to identify additional problems that need to be dealt with). *See id.* at 5.

<sup>40</sup> *Id.* at 6.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

With medication you need to be on it indefinitely, for the most part, whereas for psychotherapy, you typically need 10-12 sessions and maybe a ‘booster’ now and then...So for a patient that doesn’t want to be on medication indefinitely, that can be another motivation for them to go into psychotherapy.<sup>44</sup>

Dr. John H. Krystal of the Department of Veterans Affairs’ National Center for PTSD commented that the benefits medical professionals had believed patients were experiencing from medications most likely came from engaging the patient in other forms of treatment, such as talk therapy.<sup>45</sup> Studies have shown that some form of talk therapy either alone or in combination with an antidepressant medication, may be the best method of treatment for alleviating symptoms such as nightmares.<sup>46</sup> Knowing what kinds of treatments work best in treating PTSD is especially important when analyzing the insurance coverage American veterans receive from the United States. The Department of Veterans Affairs’ duty to provide veterans with mental health care coverage isn’t as simple as covering prescription medications. Veterans may need *both* medication and some form of talk-therapy to successfully overcome their battles with PTSD and this is often where insurers, including the Department of Veterans Affairs, fall short.

### III. WORLD WAR I

#### A. BACKGROUND

On June 28th, 1914, a Serbian nationalist shot and killed the Archduke Franz Ferdinand, the heir to the Austro-Hungarian throne, in Sarajevo.<sup>47</sup> After the assassination, the major world powers split in two: the Allies, which included Russia, France and Britain, and the Central Powers, composed of Germany, Austria-Hungary and Turkey.<sup>48</sup>

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<sup>44</sup> *Id.*

<sup>45</sup> Benedict Carey, *Drugs Found Ineffective for Veterans’ Stress*, N.Y. TIMES (Aug. 2, 2011), <http://www.nytimes.com/2011/08/03/health/research/03psych.html>.

<sup>46</sup> *Id.*

<sup>47</sup> See PUB. BROAD. SERV., *Introduction to the Great War*, PBS.ORG, <http://www.pbs.org/greatwar/chapters/index.html> (last visited Nov. 28, 2011).

<sup>48</sup> *See id.*



The United States entered the War to support the Allies in 1917 after President Woodrow Wilson encouraged the country to “make the world safe for democracy.”<sup>49</sup> On November 11, 1918, an Armistice was declared that ended the Great War.<sup>50</sup> By the time the War had ended in 1918, nine million people had died,<sup>51</sup> 116,000 thousand of whom were American soldiers.<sup>52</sup> Another 204,000 American soldiers returned to the United States wounded.<sup>53</sup>

The fortunate soldiers that did survive the massacres of World War I, wounded or not, returned home to a different world and with a different outlook on life. World War I “marked the first use of chemical weapons, the first mass bombardment of civilians from the sky, and the century's first genocide.”<sup>54</sup> This new method of warfare, like the use of chemical poison gas, heavy artillery, and trenches, subjected American soldiers to unexpected traumatic events, which contributed to what was then called “Shell Shock” or “Combat Fatigue.”<sup>55</sup> Initially, medical professionals believed that the symptoms associated with shell shock were actually attributable to a physical “shock” to the nervous system, also termed as “shelling.”<sup>56</sup> Symptoms of shell shock included staring eyes, violent tremors, blue and cold extremities, and unexplained deafness, blindness or paralysis.<sup>57</sup>

As medical professionals began to notice that the symptoms of shell shock were present in soldiers who had never experienced “shelling”, classification of the illness as a psychiatric disorder become more common.<sup>58</sup> At the time, treatment for shell shock was primarily concerned with treating the soldier as close to the traumatic event as possible.<sup>59</sup> In addition to concerns with Immediacy, other treatment considerations

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<sup>49</sup> *Id.*

<sup>50</sup> *See id.*

<sup>51</sup> *Id.*

<sup>52</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 7.

<sup>53</sup> *Id.*

<sup>54</sup> PUB. BROAD. SERV., *Introduction to the Great War*, *supra* note 47.

<sup>55</sup> Baran, *supra* note 2. *See also* Charvat, *supra* note 5 at 11, 14; PUB. BROAD. SERV., *Stalemate*, PBS.ORG, [http://www.pbs.org/greatwar/chapters/ch1\\_stalemate.html](http://www.pbs.org/greatwar/chapters/ch1_stalemate.html) (last visited Nov. 28, 2011).

<sup>56</sup> Baran, *supra* note 2.

<sup>57</sup> Charvat, *supra* note 5.

<sup>58</sup> Baran, *supra* note 2. *See also* Erica Goode, *When Soldiers Snap*, N.Y. TIMES (Nov. 8, 2009), <http://www.nytimes.com/2009/11/08/weekinreview/08goode.html>.

<sup>59</sup> Charvat, *supra* note 5.

included Simplicity, or providing simple treatment such as rest, food, and shelter, and Expectancy, or the expectation that the soldier would return to his position in the battle as soon as treatment had concluded.<sup>60</sup> In Europe, methods such as electro-shock therapy and Torpillage therapy<sup>61</sup> were also used in the hopes of curing the “hysteria” that had taken over the Allied soldiers.<sup>62</sup> Soldiers who returned home to the United States with shell shock confused the American people with the new and unheard of disorder.<sup>63</sup>

#### B. COVERAGE AND TREATMENT FOR VETERANS

Before the United States had even entered the war, Congress passed the War Risk Insurance Act of 1914 to insure American ships and their precious cargo.<sup>64</sup>

The Act was amended in 1917 both to provide soldiers with insurance against loss of life, injury, or capture by the enemy while aboard American merchant ships and to offer veterans government-subsidized life insurance.<sup>65</sup> By 1917, the Surgeon General, Rupert Blue,<sup>66</sup> recognized the

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<sup>60</sup> *Id.*

<sup>61</sup> Laurent Tatu et al., *The “Torpillage” Neurologists of World War I: Electric Therapy to Send Hysterics Back to the Front*, 75 *NEUROLOGY* 279, 280 (2010) (Torpillage, which literally means torpedoing, would include a doctor, “strongly exhort[ing] a soldier to return to a normal state of being with the help of the electric current.”).

<sup>62</sup> *Id.* at 279.

<sup>63</sup> See Baran, *supra* note 2 (“I wish you could be here in this orgie of neuroses and psychoses and gaits and paralyses....I cannot imagine what has got into the central nervous symptom of the men...Hysterical dumbness, deafness, blindness, anaesthesia galore. I suppose it was the shock and the strain, but I wonder if it was ever thus in previous wars? ...The soldier, having passed into this state of lessened control, becomes prey to his primitive instincts....He may be so affected that changes occur in his sense perceptions; he may become blind or deaf or lose the sense of smell or taste. He is cut off from his normal self and the associations that go to make up that self. Like a carriage which has lost its driver, he is liable to all manner of accidents. At night insomnia troubles him, and such sleep as he gets is full of visions; past experiences on the battlefield are recalled vividly; that will that can brace a man against fear is lacking.”) (internal quotation marks omitted).

<sup>64</sup> DEP’T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 7.

<sup>65</sup> *Id.*

<sup>66</sup> Office of the Surgeon Gen., *Previous Surgeons General*, SURGEONGENERAL.GOV, <http://www.surgeongeneral.gov/about/previous/index.html> (last visited Nov. 28, 2011).

seriousness of shell shock and as a result, created a comprehensive treatment program for those soldiers who exhibited shell shock symptoms.<sup>67</sup> The program endeavored to place a sufficient number of psychiatrists in as many combat units as possible.<sup>68</sup>

In an attempt to further understand the disorder, the United States sent Major Thomas Salmon to France to study the symptoms and possible treatments for shell shock and to make recommendations to the U.S. Army based on his research findings.<sup>69</sup> Major Salmon proposed a system of “forward psychiatry” in which hospital beds were to be cleared for mental cases, which ultimately resulted in the creation of Base Hospital No. 117 in La Fauche, France.<sup>70</sup> In October of 1917, Major Salmon reported that one-seventh of all discharges from the British Army were attributable to shell shock.<sup>71</sup>

Two years later, in 1919, Congress passed a law as part of the War Risk Insurance Act, which placed the Public Health Service in charge of veterans’ medical care, transferred several military hospitals to the Public Health Service, and also authorized the establishment of new hospitals in the hope of overcoming the large burden that had been placed on armed services hospitals.<sup>72</sup> In 1921, with the purpose of consolidating veterans programs managed by three different agencies, Congress created the Veterans’ Bureau, headquartered in Washington, D.C.<sup>73</sup> Just three years later in 1924, General Frank T. Hines, the second director of the Bureau, reorganized the Bureau into six different services: medical and rehabilitation, claims and insurance, finance, supply, planning and control.<sup>74</sup>

Although society and its mental health professionals of the time period had moved towards understanding and classifying shell shock as a mental disorder, adequate mental health care coverage and effective

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<sup>67</sup> Charvat, *supra* note 5.

<sup>68</sup> *Id.*

<sup>69</sup> Edgar Jones et al., *Shell Shock and Mild Traumatic Brain Injury: A Historical Review*, 164 AM. J. PSYCHIATRY 1641, 1642.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> DEP’T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 7.

<sup>73</sup> DEP’T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 8 (These agencies included the Bureau of War Risk Insurance, Public Health Service and the Federal Board of Vocational Education. The consolidation did not encompass the Bureau of Pensions of the Interior Department and the National Homes for Disabled Volunteer Soldiers, which remained separately administered).

<sup>74</sup> *Id.*

treatments for shell shock were almost nonexistent by the end of the War. In addition, the movement from defining shell shock as a physical illness to a mental disorder greatly affected not only the methods of treatment used to treat shell shock but the stigma that the surviving soldiers returned home to as well.<sup>75</sup> If the explanation for shell shock was physical, such as a breakdown or withering of the nerves in the brain, treatments such as rest, massage and electroshock therapy were used.<sup>76</sup> One commentator remembered, “with what tenacity men clung to a diagnosis of ‘shell shock’... something which was generally recognized as incapacitating and warranted treatment in a hospital.”<sup>77</sup> As a result, the stigma associated with shell shock was not as prevalent because it was viewed as a physical disorder or “neurological lesion.”<sup>78</sup> When the source of the illness became psychological however, rest, the “talking cure”, and hypnosis became the recommended treatment.<sup>79</sup>

Consequently, male soldiers who had been seen as the strong defenders of our country were now weakened and emasculated by their psychological diagnosis. In all such psychological treatments for shell shock, occupational retraining and the “inculcation of masculinity” were highly recommended for all soldiers.<sup>80</sup> One medical supervisor at a military hospital informed all medical officers that although they were required to show sympathy to all shell shock patients, “the patient must be induced to face his illness in a manly way.”<sup>81</sup> When symptoms became apparent on the battlefield, men were often dismissed with little sympathy.<sup>82</sup> Upon returning home and entering military hospitals for shell shock treatment, soldiers were met with even less sympathy; veterans were greeted in silence and hung their heads in “inexplicable shame” as they entered the hospital.<sup>83</sup> It is therefore unsurprising that in a country with such little understanding and sympathy for a condition as serious as shell shock, there

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<sup>75</sup> Joanna Bourke, *Shell Shock During World War One*, BBC HISTORY (Mar. 10, 2011), [http://www.bbc.co.uk/history/worldwars/wwone/shellshock\\_01.shtml](http://www.bbc.co.uk/history/worldwars/wwone/shellshock_01.shtml).

<sup>76</sup> *Id.*

<sup>77</sup> Jones et al., *supra* note 69, at 1644.

<sup>78</sup> *Id.*

<sup>79</sup> Bourke, *supra* note 75. *See also* Jones et al., *supra* note 69, at 1644 (“Only in 1917, when the military authorities deliberately discouraged use of the term and suggested an association with malingering, did it become a controversial diagnosis.”).

<sup>80</sup> Bourke, *supra* note 75.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

was inadequate mental health coverage to assist veterans in their recovery. The United States' inability to define and understand PTSD meant that government-sponsored coverage and treatment were moved to the bottom of the Veterans Bureau's list of priorities.

#### IV. WORLD WAR II

##### A. AFTERMATH OF WORLD WAR I

By the end of World War I, much of the United States had felt that the War was a monumental mistake, never to be repeated again.<sup>84</sup> For years, the United States focused on everything but its armed forces, which were composed of too few men, outmoded and rusty equipment, and dwindling spirits.<sup>85</sup> By the time the Great Depression hit, however, America's people were without jobs and thus, eager to go back to work.<sup>86</sup> This excitement and energy that had infected the American population would mobilize people to remodernize its armed forces. This patriotic enthusiasm would translate into the way Americans felt about World War II.

In 1930, Congress created the Veterans Administration ("VA") by consolidating the Veterans' Bureau, the Bureau of Pensions, and the National Homes for Disabled Volunteer Soldiers.<sup>87</sup> President Herbert Hoover signed the executive order establishing the VA on July 21, 1930.<sup>88</sup> Brigadier General Frank T. Hines, who had served as the Director of the Veterans' Bureau since 1923, was appointed as the first administrator of the VA and would remain in that position until 1945.<sup>89</sup> The new VA was accountable for medical services and coverage for veterans, allowances and disability compensation for World War I veterans, life insurance and other benefits such as pensions and retirement payments.<sup>90</sup> In the next ten years, General Hines and the new VA would expand the number of VA hospitals from sixty-four to ninety-one and would increase the number of beds from

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<sup>84</sup> PUB. BROAD. SERV., *The Perilous Fight: Building an Army*, PBS.ORG (2003), [http://www.pbs.org/perilousfight/battlefield/building\\_an\\_army/](http://www.pbs.org/perilousfight/battlefield/building_an_army/).

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

<sup>87</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 12.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.* See also DEP'T OF VETERAN AFFAIRS, *VA History*, [http://www.va.gov/about\\_va/vahistory.asp](http://www.va.gov/about_va/vahistory.asp) (last visited Dec. 21, 2011).

<sup>90</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 12.

33,669 to 61,849.<sup>91</sup> It seemed that both the American people and government were beginning to realize that resources were required to help these veterans acclimate to citizen life once again.

## B. BACKGROUND

On Sunday, December 7th, 1941, Japanese aircraft fighters launched an attack on Pearl Harbor, which killed 2,400 Americans stationed in Hawaii.<sup>92</sup> Another 1,200 Americans that had been burned or maimed in the attack were sent to the already over-crowded hospitals in nearby Oahu.<sup>93</sup> President Franklin Roosevelt immediately declared war on Japan and less than one week later on December 11<sup>th</sup>, Adolf Hitler declared war on the United States.<sup>94</sup>

Learning from the effects of shell shock on its veterans during World War I, the United States Army conducted extensive psychiatric screenings of its soldiers before deploying them overseas. The military established such screenings with the intention of identifying the soldiers that might be vulnerable to developing psychological problems in combat environment due to “defects” such as personality flaws or inherent psychological neuroses.<sup>95</sup> Unfortunately, because pre-deployment screening for possible future behavior indicators was new to the American psychiatric world, screening was imprecise and extremely unreliable.<sup>96</sup>

Unfortunately, because pre-deployment screening for possible future behavior indicators was new to the American psychiatric world, screening was imprecise and extremely unreliable.<sup>97</sup>

In all, over sixteen million Americans enlisted in World War II. By the end of the War in 1945, over 400,000 Americans had been killed, and

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<sup>91</sup> *Id.* See also DEP’T OF VETERANS AFFAIRS, *VA History*, *supra* note 89 (stating there were only fifty-four VA hospitals in 1930).

<sup>92</sup> PUB. BROAD. SERV., *The Perilous Fight: Pearl Harbor*, PBS.ORG, [http://www.pbs.org/perilousfight/battlefield/pearl\\_harbor/](http://www.pbs.org/perilousfight/battlefield/pearl_harbor/) (last visited Nov. 28, 2011).

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> Madelyn Hsiao-Rei Hicks, *Mental Health Screening and Coordination of Care for Soldiers Deployed to Iraq and Afghanistan*, 168 AM. J. PSYCHIATRY 341, 341 (2011).

<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

almost another 700,000 men had been wounded.<sup>98</sup> The total number of reported fatalities for all who participated in World War II varies from thirty-five million to sixty million.<sup>99</sup> The destruction of World War II, less than thirty years after the devastation of World War I, sparked the beginning of different shell shock symptoms in soldiers who survived long enough to experience trauma.<sup>100</sup> Just as the United States had experienced new chemical and trench warfare in World War I, advances in technology and the creation of innovative atrocities in World War II took a very devastating psychological toll on American troops and lead to the development of a “new shell shock.”<sup>101</sup> The newly invented atomic bomb that the United States dropped over Nagasaki and Hiroshima in August of 1945 killed approximately 375,000 people instantly and continued killing thousands more in the following decades from radiation poisoning.<sup>102</sup> American soldiers, although following orders, were forced to realize that the bomb President Truman had promised would never be used on women and children had killed—and would continue to kill—innocent civilians for years to come.<sup>103</sup> In addition to the horror of the atomic bomb, the atrocities that American soldiers viewed when liberating German concentration camps traumatized much of the United States’ military force for many years.<sup>104</sup> Many soldiers did not believe that such devastation was actually happening, and many would not have believed it if they had not seen it.<sup>105</sup> In comparison to the warfare in the First World War, World War II was

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<sup>98</sup> ANNE LELAND & MARI-JANA OBOBOCEANU, CONG. RESEARCH SERV., RL 32492, AM. WAR & MILITARY OPERATIONS CASUALTIES: LISTS & STATISTICS (2010). *See also* DEP’T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 13 (“Some 671,817 men and women had been wounded and 405,399 had been killed. Hundreds of thousands of dependents were left in need.”).

<sup>99</sup> *World War II*, ENCYCLOPEDIA BRITANNICA ONLINE, *available at* <http://www.britannica.com/EBchecked/topic/648813/World-War-II> (last visited Feb. 18, 2013).

<sup>100</sup> *See* Goode, *supra* note 58, (although shell shock was still very much in the forefront of the United States’, newly-developed symptoms were different enough from the symptoms in World War II that the diagnosis of “shell shock” was replaced with other definitions for newly-defined mental illnesses).

<sup>101</sup> *See infra* pp. 89.

<sup>102</sup> PUB. BROAD. SERV., *The Perilous Fight: The Atomic Option*, PBS.ORG, [http://www.pbs.org/perilousfight/psychology/the\\_atomic\\_option/](http://www.pbs.org/perilousfight/psychology/the_atomic_option/) (last visited Nov. 28, 2011).

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

[A] greater horror for the 800,000 men in extended combat... Bigger field weapons meant soldiers fought in small units dispersed over more territory, without the company camaraderie that sustained WWI doughboys. Bomber crews could kill more people from afar, but at significantly greater risk from enemy fighters and anti-aircraft fire. At sea, enemy planes and submarines could turn the mightiest warship into a sinking inferno in minutes.<sup>106</sup>

The “new shell shock” of World War II manifested itself in symptoms such as nightmares, anxiety, and startled reactions.<sup>107</sup> Other symptoms included headaches, dizziness, fatigue, memory loss, and poor concentration.<sup>108</sup> The new disorder, which no longer included trembling or paralysis as it did during World War I, was renamed “combat fatigue,”<sup>109</sup> “war neurosis,”<sup>110</sup> or, most notably, “postconcussional syndrome.”<sup>111</sup> The treatments for these newly defined disorders were heavily influenced by Freudian psychoanalytic theories,<sup>112</sup> which had taken hold in the United States in between the two World Wars.<sup>113</sup> Psychiatrists and other

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<sup>106</sup> PUB. BROAD. SERV., *The Perilous Fight: The Mental Toll*, [http://www.pbs.org/perilousfight/psychology/the\\_mental\\_toll/](http://www.pbs.org/perilousfight/psychology/the_mental_toll/) (last visited Mar. 14, 2013).

<sup>107</sup> Goode, *supra* note 58.

<sup>108</sup> See also Jones et al., *supra* note 69, at 1643.

<sup>109</sup> See Charvat, *supra* note 5.

<sup>110</sup> See Goode, *supra* note 58.

<sup>111</sup> See Jones et al., *supra* note 69, at 1643.

<sup>112</sup> Goode, *supra* note 58; see Charvat, *supra* note 5 (Another theory for treating combat fatigue rested upon the concept of unit cohesion among soldiers and its connection to resilience in soldiers who had experienced combat fatigue symptoms. Consequently, replacement troops were more susceptible to combat fatigue than tired, seasoned veterans because they lacked such cohesion amongst their fellow soldiers).

<sup>113</sup> See *Contributions of Psychoanalysis*, AM. PSYCHOANALYTIC ASS'N, APSA.ORG, [http://www.apsa.org/About\\_Psychoanalysis/Contributions\\_of\\_Psychoanalysis.aspx](http://www.apsa.org/About_Psychoanalysis/Contributions_of_Psychoanalysis.aspx) (last visited Dec. 21, 2011) (“Psychoanalysis became established in America between World War I and World War II, when Americans traveled to Europe to take advantage of psychoanalytic training opportunities there. The single major therapeutic perspective that was transplanted to the United States was ego psychology, based centrally on Sigmund Freud’s *The Ego and the Id* (1923) and *The Problem of Anxiety* (1936), followed by Anna Freud’s *Ego and the Mechanisms of Defense* (1936) and Heinz Hartmann’s *Psychoanalysis and the*



medical professionals in the field experimented with other treatments as well, such as sodium pentathol, in an attempt to get the soldiers to relive their repressed battlefield experiences and thus reach catharsis.<sup>114</sup> Others like Flight Surgeon Jack McKittrick found that distributing alcohol before a flight mission best calmed the men when they most needed it.<sup>115</sup>

One in four casualties during World War II was attributable to combat fatigue, and for soldiers involved in long-term, intense fighting, the ratio was one in two.<sup>116</sup> Combat fatigue was more common in certain combat zones and in the Pacific where, for example, forty percent of combat evacuations were “mental” in nature, and over 26,000 psychiatric cases were reported in Okinawa alone.<sup>117</sup> To keep soldiers from going mad and losing their composure in anticipation of kamikaze attacks,<sup>118</sup> soldiers were not informed that an attack was mounting until they absolutely needed to know.<sup>119</sup> During World War II, 1,393,000 soldiers were treated for battle fatigue and of all ground combat troops; thirty seven percent were discharged for psychiatric reasons.<sup>120</sup>

The classification of postconcussional syndrome or combat fatigue as either physical or mental was, once again, a difficult one to make. As one author put it, “[d]isagreement about etiology followed tracks laid down during World War I.”<sup>121</sup> The symptoms of postconcussional syndrome were often quite difficult to differentiate from symptoms of a severe brain injury.<sup>122</sup> While medical professionals did their best to differentiate

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*Problem of Adaptation* (1939). This perspective of psychoanalysis was dominant in America for approximately a 50-year span until the 1970s.”).

<sup>114</sup> PUB. BROAD. SERV., *The Perilous Fight: The Mental Toll*, *supra* note 106.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> *Kamikaze*, ENCYC. BRITANNICA ONLINE, <http://www.britannica.com/EBchecked/topic/310634/kamikaze> (last visited Feb. 18, 2013) (“A kamikaze attack was a military tactic used during World War II in which Japanese pilots would deliberately crash fighter planes into a target, usually a ship. Such a crash would result in the pilot’s death and very often, because the planes were often loaded with gasoline and other bombs, in many other deaths as well.”)

<sup>119</sup> PUB. BROAD. SERV., *The Perilous Fight: The Mental Toll*, *supra* note 106.

<sup>120</sup> *Id.*

<sup>121</sup> Jones et al., *supra* note 69, at 1643.

<sup>122</sup> *Id.* (stating that “the problem of distinguishing such cases from organic concussion resulting from blast is delicate and often difficult.”).

between an organic head injury and postconcussional syndrome,<sup>123</sup> studies on the differences between the two did not support a differentiation.<sup>124</sup> Instead, the medical world came to the conclusion that "the practice of dividing the postcontusional cases into two groups, labeling the one organic and the other functional or neurotic [was]...unprofitable and misleading."<sup>125</sup> As a result, the stigma soldiers experienced upon being diagnosed with shell shock in World War I<sup>126</sup> had barely changed with the newly developed symptoms of postconcussional syndrome in World War II. Some commentators believed, however, that "except for a few blood-n'-guts hardliners like Generals George Patton and Curtis LeMay, the brass no longer thought combat fatigue was evidence of cowardice or a pre-war neurosis."<sup>127</sup> Although mental, combat fatigue was still a wound and many believed that more than anything else, affected soldiers were simply overly-fatigued.<sup>128</sup>

#### C. COVERAGE AND TREATMENT FOR VETERANS

Due in part to the United States' growing concerns with helping veterans in their transition back to civilian life and in the hopes of decreasing the possibility of a post-war depression, Congress responded by passing the Servicemen's Readjustment Act of 1944, or the "GI Bill of Rights."<sup>129</sup> The GI Bill had three different types of benefits for veterans.<sup>130</sup>

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<sup>123</sup> Jones et al., *supra* note 69, at 1643. One author believed that in examining the timing and number of individual symptoms, one could distinguish between severe head injuries and postconcussional syndrome. Immediate and severe symptoms with a trend towards progressive recovery were indicative of a physically defined head injury while a delay in the onset of symptoms with a tendency of getting worse with time was indicative of postconcussional syndrome. These observations were also been made by other medical authorities in the aftermath of World War I, "instead of passing away in a few days, as they normally do, [symptoms] begin after a comparatively free interval, become apparent again with a definite degree of persistence and exaggeration." *Id.*

<sup>124</sup> *See id.*

<sup>125</sup> *See id.*

<sup>126</sup> *See infra* p. 89.

<sup>127</sup> PUB. BROAD. SERV., *The Perilous Fight: The Mental Toll*, *supra* note 106.

<sup>128</sup> *See id.* ("The First Armored Division reported that by givingamentals complete rest in a safe area near the front, plus hot meals and a bath, 50-70% returned to combat within three days.") (internal quotation marks omitted).

<sup>129</sup> *See Servicemen's Readjustment Act (1944)*, OURDOCUMENTS.GOV, <http://www.ourdocuments.gov/doc.php?flash=true&doc=76> (last visited Nov. 28,

The first benefit provided veterans with up to four years of education or training, the second provided veterans with federally guaranteed farm, business or home loans without a requisite down payment, and the third provided for unemployment compensation.<sup>131</sup> When the World War II GI Bill expired in 1956, approximately 7.8 million veterans had received some form of training and the VA had guaranteed approximately 5.9 million home loans totaling approximately fifty billion dollars.<sup>132</sup> In the same year, Congress also passed the Veterans' Preference Act of 1944, which gave veterans hiring preference where federal funding was involved.<sup>133</sup> Although Congress, the VA and the United States as a whole were certainly becoming more involved in and concerned with veterans' benefits, there was a very apparent gap in coverage for health care and more specifically, mental health care. The lack of evidence for any mental health care coverage is in and of itself indicative of how society in this time period viewed mental illness. It is safe to say that society chose not to view mental illness at all, in fact. It would not be until years later that American veterans would begin to see the government-sponsored mental health coverage and treatment that they deserved. Until then, however, public conceptions of mental illness and mental health treatment would directly affect the VA's coverage for such services—or lack thereof.

The 1999 Surgeon General's Report on mental illness included an overview of the public attitudes and understanding of mental illness in the 1950s, the era immediately succeeding the end of World War II.<sup>134</sup> The Report came to the conclusion that in the 1950s, the public had a very

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2011). *See also* DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 13.

<sup>130</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 13. *See also Serviceman's Readjustment Act (1944)*, *supra* note 129.

<sup>131</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 13-14 (the education provision included up to \$500 a school year for tuition, fees, books and an additional monthly allowance for additional expenses. The second provision stated that veterans could apply for loans up to \$2,000 with a half of that being guaranteed by the federal government. Lastly, the unemployment compensation provision mandated that veterans who had served at least ninety days were allowed \$20 per week for a maximum of fifty-two weeks). *See also Serviceman's Readjustment Act (1944)*, *supra* note 129.

<sup>132</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 14.

<sup>133</sup> Veterans' Preference Act of 1944, Pub. L. No. 78-359, § 2, 58 Stat. 387, 387 (1944). *See also* DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 14.

<sup>134</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 20, at 7.

unscientific understanding of mental illness, which, in turn, resulted in a highly stigmatized view of mental illnesses as a whole.<sup>135</sup> The intense stigma that had infected society during the time period was linked with the fear that a mentally ill person would be susceptible to unpredictable and violent behavior.<sup>136</sup> The public was typically unable to distinguish those with mental illnesses from people who were generally unhappy and tended to see only extreme forms of behavior or symptoms, such as those exhibited in psychotic disorders, as mental illnesses.<sup>137</sup>

The lack of both private and government-funded coverage for mental health services was not surprising considering society's rudimentary understanding of mental illness which was accompanied by intense stigma. In the aftermath of the two World Wars in less than a fifty-year period, the United States government had other, more "physical" concerns such as those enumerated in the GI Bill to focus its resources and energy on. Although, once again, the United States as a whole had made great progress in caring for veterans who had sacrificed life and limb for their country, those who needed insurance coverage for mental health treatment fell in between the gaps left by the VA's insurance coverage. In the years to come, however, the United States would be confronted with a mental epidemic of sorts that simply could not be ignored. Symptoms of mental illnesses such as shell shock, battle fatigue, and postconcussional syndrome would continue to persist in those who had served. With the United States' involvement in the Vietnam War, the American people would be forced to face mental illnesses on a scale that had never been seen before.

## V. VIETNAM WAR

### A. AFTERMATH OF WORLD WAR II

In the years following the demobilization of World War II, the number of veterans in the United States jumped to more than fifteen million.<sup>138</sup> To compensate for this enormous growth, the number of VA hospitals also increased from ninety-seven to 151 in the years between 1942 and 1950.<sup>139</sup> Each year, 2.5 million veterans received outpatient and

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<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

dental care at VA facilities and another 2.5 million veterans and their dependents received \$125 million in compensation and pensions each month.<sup>140</sup> To meet the growing number of veterans' claims, the VA was reorganized in 1953 into three separate departments including the Department of Medicine and Surgery, the Department of Veterans Benefits, and the Department of Insurance.<sup>141</sup> In the following years, the VA would continue expanding its research and increasing its funding on chronic care problems such as age.<sup>142</sup> Other programs such as the Ex-Servicemen's Unemployment Compensation Act of 1958 would establish a system of unemployment insurance for both deployed and peacetime veterans.<sup>143</sup> In the years leading up to the Vietnam War, benefits and programs were increased in number and importance but the VA had still not focused its funding or energies—at least not explicitly—on veterans' mental health.

#### B. BACKGROUND

In the aftermath of World War II and the world of “combat fatigue”, “postconcussional syndrome”, and “war neurosis”,<sup>144</sup> American psychiatrists renamed the disorder “stress response syndrome” or “gross stress reaction” and included the condition in the first edition of the Diagnostic and Statistical Manual of Mental Disorders, or the DSM.<sup>145</sup> The DSM stated, “Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear...When promptly and adequately treated, the condition may clear rapidly.”<sup>146</sup> The DSM restricted diagnosis to those soldiers who were in combat and who had experienced a “civilian catastrophe” such as a fire or explosion.<sup>147</sup>

After North Vietnam had defeated the French Colonial administration of Vietnam in 1954, the new government and its allies within South Vietnam, the Viet Cong, tried to unify the two parts of the

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<sup>140</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 20, at 7.

<sup>141</sup> *Id.*

<sup>142</sup> *Id.* at 16-17.

<sup>143</sup> *Id.* at 17.

<sup>144</sup> *See infra* p. 89.

<sup>145</sup> Charvat, *supra* note 5; Baran, *supra* note 2, at 4-5.

<sup>146</sup> Baran, *supra* note 2, at 5.

<sup>147</sup> *Id.*

country into one coherent communist regime much like China.<sup>148</sup> The South Vietnamese government, on the other hand, fought for a more Western-like form of government, like its allies the United States.<sup>149</sup> Although there was an American presence in South Vietnam throughout the 1950s, U.S. presence began increasing on a large scale in 1961.<sup>150</sup> By 1965, the United States had introduced active combat units and by 1969, more than 500,000 American military work forces were present in South Vietnam.<sup>151</sup> Incidentally, the American Psychiatric Association chose to remove “gross stress reaction” from the DSM in 1968<sup>152</sup> and to instead combine all trauma-related disorders into a category titled “situational disorders” in the DSM-II.<sup>153</sup> As a result, mental health professionals could no longer diagnose a veteran or soldier in active duty with a combat-related illness.<sup>154</sup> For those veterans returning home, the lack of a concrete diagnosis made it difficult both for mental health professionals to assess health and disability benefits and for the soldiers to receive any mental health coverage.<sup>155</sup> Once again, it seemed as if the United States government had placed other veterans’ issues well above mental health coverage and treatment. The removal of gross-stress reduction from the DSM-III certainly contributed to the invisibility of American soldiers’ plight with PTSD and as a result, coverage and treatment remained beyond veterans’ grasps.

For the next four years, the United States would continue fighting and assisting South Vietnam while other countries, like the Soviet Union and China would provide North Vietnam with weapons, supplies, and military advisors.<sup>156</sup> With “gross stress reaction” having been removed from the DSM, officials classified many soldiers exhibiting symptoms as having “character disorders” and focused their energies on rectifying these “behavioral problems” instead of seeking the diagnosis of a mental illness.<sup>157</sup> Around the same time, a group of “anti-war psychiatrists” led by

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<sup>148</sup> *Vietnam War*, ENCYC. BRITANNICA ONLINE, available at <http://www.britannica.com/EBchecked/topic/628478/Vietnam-War> (last visited Feb. 18, 2013).

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> Baran, *supra* note 2, at 5.

<sup>153</sup> Charvat, *supra* note 5, at 18.

<sup>154</sup> Baran, *supra* note 2, at 5.

<sup>155</sup> *Id.*

<sup>156</sup> See ENCYC. BRITANNICA ONLINE, *supra* note 148.

<sup>157</sup> Baran, *supra* note 2 (follow “Vietnam War” hyperlink).

Chaim Shatan and Robert Jay Lifton created a new diagnostic theory to describe the psychological trauma that veterans had sustained in the Vietnam War. The group called the disorder “Post-Vietnam Syndrome,” symptoms of which included “growing apathy, cynicism, alienation, depression, mistrust, and expectation of betrayal as well as an inability to concentrate, insomnia, nightmares, restlessness, uprootedness, and impatience with almost any job or course of study.”<sup>158</sup> Shatan and Lifton claimed it was not uncommon for symptoms of Post-Vietnam Syndrome to emerge months or years after veterans returned home.<sup>159</sup>

In 1973, the United States withdrew from Vietnam because it could not bear the physical and monetary costs and by 1975, South Vietnam had completely fallen to the North Vietnamese government.<sup>160</sup> As a result of the Vietnam War, as many as two million civilians and 1.35 million soldiers and Viet Cong fighters had died.<sup>161</sup> In addition, the United States had lost over 58,000 men and woman in their struggle to support the fight against communism.<sup>162</sup>

#### C. COVERAGE AND TREATMENT FOR VETERANS

At first, Congress limited benefits for the Vietnam War to those who had served between August 5, 1964 and May 7, 1975.<sup>163</sup> Soon after, Congress increased the time period to service beginning on February 28, 1961.<sup>164</sup> During this time period, more than six million Vietnam veterans had been discharged.<sup>165</sup> One of the major differences found in Vietnam-era veterans as compared to those in previous wars was the enormous number of veterans who returned home disabled.<sup>166</sup> Due to even more advances in medical and airlift technology, many veterans who would have died in

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<sup>158</sup> Sally Satel, *The Battle Over Battle Fatigue*, WALL ST. J., July 17, 2010, available at <http://online.wsj.com/article/SB10001424052748704913304575371130876271708.html>.

<sup>159</sup> *See id.*; *see also* Chaim F. Shatan, *Post-Vietnam Syndrome*, N.Y. TIMES, May 6, 1972, at 35.

<sup>160</sup> *See* ENCYC. BRITANNICA ONLINE, *supra* note 148.

<sup>161</sup> *See id.*

<sup>162</sup> *See id.*

<sup>163</sup> *See* DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 18.

<sup>164</sup> *See id.*

<sup>165</sup> *See id.*

<sup>166</sup> *See id.*

previous wars survived, albeit mentally or physically disabled.<sup>167</sup> The return of veterans to civil life within days of leaving combat was also new and by 1972, 308,000 veterans with disabilities connected to military service had returned home.<sup>168</sup>

The quick transition from combat to civilian life in combination with the strong anti-war sentiments infecting the United States at the time caused greater adjustment difficulties than found in previous wars.<sup>169</sup> Additionally, the United States' withdrawal from Vietnam in 1973<sup>170</sup> corresponded with an economic recession on the home front.<sup>171</sup> As a result, a large number of veterans were unemployed and many reported feeling isolated and alienated from friends, family, and society in general.<sup>172</sup> In response to the mounting stressors on Vietnam veterans, Congress passed the Veterans' Readjustment Benefits Act, also called the Vietnam GI Bill.<sup>173</sup> "Under this Act, veterans who had been on active duty for more than 180 consecutive days were entitled to one month of educational assistance for each month of service."<sup>174</sup> The Servicemen's Group Life Insurance program was also instituted in the Vietnam era, which provided soldiers with a maximum of ten thousand dollars of coverage.<sup>175</sup> "Similar coverage was extended to veterans under the Veterans Group Life Insurance program."<sup>176</sup> Finally, Congress created the Veterans Mortgage Life Insurance program, to provide a program of mortgage life insurance for severely disabled veterans who needed grants for special housing

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<sup>167</sup> *See id.*

<sup>168</sup> *See id.*

<sup>169</sup> *See id.*

<sup>170</sup> *See* ENCYC. BRITANNICA ONLINE, *supra* note 148.

<sup>171</sup> *See* DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 18. *See also* MARC LABONTE, CONG. RESEARCH SERV., RL 31237, THE CURRENT ECONOMIC RECESSION: HOW LONG, HOW DEEP, AND HOW DIFFERENT FROM THE PAST? 17-20 (2002).

<sup>172</sup> *See* DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 18.

<sup>173</sup> 38 U.S.C. §101 (2006).

<sup>174</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 18 (benefit was later increased to one and one half month of educational assistance per each month of service).

<sup>175</sup> *Id.* at 19. *See also* *Servicemembers & Veterans' Group Life Insurance*, U.S. DEP'T OF VETERANS AFFAIRS, <http://www.insurance.va.gov/sglisite/sgli/sgli.htm> (last visited Apr. 21, 2013) (today, coverage is available in \$50,000 increments up to a maximum of \$400,000).

<sup>176</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 19.



accommodations due to their war-related disabilities up to a maximum of thirty thousand dollars.<sup>177</sup> For the first time, the VA also began instituting outreach programs to bring VA benefits to the attention of Vietnam soldiers.<sup>178</sup> VA representatives were sent to Vietnam to assist soldiers before they were discharged and by 1967, the VA had also installed toll-free telephones to regional offices in each state.<sup>179</sup> In addition, counselors were stationed at separation centers and follow-up letters were sent to those soldiers who did not respond to the VA's initial outreach attempts.<sup>180</sup>

Although health programs such as the Radiation-Exposed Veterans Compensation Act of 1988 were created to handle specific health issues such as Agent Orange exposure,<sup>181</sup> by the end of the war, the VA had still not instituted any formal coverage or assistance programs specifically geared towards mental health programs for veterans with PTSD. As a result, veterans were left without adequate treatment, assistance or coverage for a chronic, highly-stigmatized, and debilitating disorder.

## VI. THE CURRENT CONFLICTS IN THE MIDDLE EAST

### A. AFTERMATH OF VIETNAM

The time period following the Vietnam War was marked by an increased focus on veterans' benefits and a major season of change in the armed forces.<sup>182</sup> The Government, the VA, and the general American public became increasingly educated on veterans' issues including mental health and as a result, new legislation and programs were enacted. Programs such as the Post-Vietnam Era Veterans' Educational Assistance Act of 1977, the Veterans' and Survivors' Pension Improvement Act of 1978, and the VA's special tribute to deceased Medal of Honor recipients in 1976 all increased the American public's awareness of issues veterans were facing on a daily basis.<sup>183</sup> Until the passage of the Veterans Health Care Amendments Act of 1979, which established a network of Veterans' Centers across the country, and Congress' 1980 authorization for Geriatric

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<sup>177</sup> *Id.* (by 1992, coverage had increased to \$90,000).

<sup>178</sup> *Id.*

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

<sup>181</sup> DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 20-21.

<sup>182</sup> *See id.* at 22.

<sup>183</sup> *Id.* at 22-23 (Arlington National Cemetery and the Soldiers' Home National Cemetery were not transferred to the VA, however).

Research, Education and Clinical Centers, which researched and coordinated veterans' geriatric medicine, very little of the VA's advocacy had been focused on health care coverage, access or assistance.<sup>184</sup> Finally, in 1986, Congress established income-based eligibility assessment protocols for determining whether or not veterans were eligible for free medical care.<sup>185</sup> By passing Public Law Number 99-272 in 1986, Congress established three categories of veterans to determine their eligibility for health care.<sup>186</sup> Veterans in Category A, the veterans with the most need, were provided with free hospital care and were eligible for outpatient and nursing home care.<sup>187</sup> Veterans assigned to either Category B or C based on income and net worth were provided with care on a resource-available basis.<sup>188</sup> Although the VA health care reform of 1986 didn't specifically address mental health, the VA began dedicating resources to serving the homeless and the chronically mentally ill by the late 1980s.<sup>189</sup> In 1984, recognizing the mounting problems with PTSD in veterans, Congress created the Special Committee on Post-Traumatic Stress Disorder, which was composed of PTSD specialists from across the DVA's Mental Health and Readjustment Counseling Services.<sup>190</sup> The Committee was created to determine the DVA's ability to provide assessment and treatment for PTSD and to encourage the DVA's educational, research and benefits activities concerning PTSD.<sup>191</sup>

In 1988, President Ronald Reagan elevated the VA to Cabinet status and, on March 15, 1989, the VA was renamed the Department of

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<sup>184</sup> *Id.* at 23 (at first, in response to the increasing demand for Vietnam veterans, these Vet Centers provided services only to Vietnam veterans).

<sup>185</sup> *Id.*

<sup>186</sup> See SIDATH VIRANGA PANANGALA, CONG. RESEARCH SERV., RL 32961, VETERANS' HEALTH CARE ISSUES IN THE 109TH CONGRESS 5 (2006). See also DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 23.

<sup>187</sup> RL 32961 at 5-6 ("These Category A veterans were defined to include those with service-connected disabilities, low-income veterans without such disabilities, and certain 'exempt' veterans, including (for example) former prisoners of war, those exposed to Agent Orange, recipients of VA pensions, and those eligible for Medicaid.").

<sup>188</sup> *Id.*

<sup>189</sup> See DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 24.

<sup>190</sup> See RL 32961 at 22.

<sup>191</sup> *Id.*

Veterans Affairs.<sup>192</sup> The DVA was reorganized into three main parts, which included the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery System.<sup>193</sup> During the Persian Gulf War, Congress passed the Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act, which, among other benefits, offered psychological counseling at Vet Centers for veterans having trouble transitioning back to civilian life.<sup>194</sup> Finally, veterans with mental illnesses were being specifically addressed in Congress' attempt to offer more coverage and services for both veterans and soldiers still in combat. In 1995, the VA's Hospitals were consolidated into twenty-two Veterans Integrated Service Networks. The effects of this reorganization included "population-based planning, decentralization, universal availability or primary care, a shift to outpatient care from inpatient care, and an emphasis on measuring health-care performance on the outcome of patient treatment."<sup>195</sup>

Advances in the psychiatric world were also taking place in the post-Vietnam era. In 1980, the American Psychiatric Association introduced "Post-traumatic Stress Disorder" into the third edition of the DSM by placing the disorder in a sub-category of anxiety disorders.<sup>196</sup> Although the formal inclusion of the illness in the DSM-III was a monumental step in the right direction for veterans' rights to mental health care, one of the most important changes the DSM-III's definition ushered in was "the stipulation that the etiological agent was outside the individual (i.e., a traumatic event) rather than an inherent individual weakness (i.e., a traumatic neurosis)."<sup>197</sup> As a result, the tug of war that had previously existed between defining PTSD as biological *or* behavioral was coming to an end due in part to advances in research and to society's greater understanding of mental health. One of the most fundamental concepts included in this new disorder was a necessary understanding of what constituted "trauma" for the purposes of PTSD under the DSM-III.<sup>198</sup>

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<sup>192</sup> See DEP'T OF VETERANS AFFAIRS, VA HISTORY IN BRIEF, *supra* note 14, at 26.

<sup>193</sup> See *id.*

<sup>194</sup> *Id.* at 27.

<sup>195</sup> *Id.* at 29.

<sup>196</sup> Matthew J. Friedman, *Posttraumatic Stress Disorder: An Overview*, DEP'T OF VETERANS AFFAIRS (Dec. 20, 2011), <http://www.ptsd.va.gov/professional/pages/ptsd-overview.asp>. See also Charvat, *supra* note 5.

<sup>197</sup> *Id.*

<sup>198</sup> *Id.* ("In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human

Although the diagnostic criteria for PTSD in the DSM have been revised several times since its initial formulation in 1980, the mere fact that a formal diagnosis has been entered into the DSM was a great victory for veterans and their well-deserved mental health care rights.<sup>199</sup>

## B. BACKGROUND

The day after the September 11<sup>th</sup> attacks on the United States in 2001, President George W. Bush declared a war on terror. After the Taliban refused to hand over al Qaeda leader, Osama Bin Laden, American and British forces began airstrikes on Afghanistan. October of 2001 marked the beginning of Operation Enduring Freedom<sup>200</sup> and by August of 2003, the North Atlantic Treaty Organization had also deployed troops to Afghanistan for a peacekeeping mission.<sup>201</sup> Later, the deployed soldiers would expand both in numbers and in geographical location to over eleven

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experience. The framers of the original PTSD diagnosis had in mind events such as war, torture, rape, the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, natural disasters (such as earthquakes, hurricanes, and volcano eruptions), and human-made disasters (such as factory explosions, airplane crashes, and automobile accidents). They considered traumatic events to be clearly different from the very painful stressors that constitute the normal vicissitudes of life such as divorce, failure, rejection, serious illness, financial reverses, and the like. (By this logic, adverse psychological responses to such ‘ordinary stressors’ would, in DSM-III terms, be characterized as Adjustment Disorders rather than PTSD.) This dichotomization between traumatic and other stressors was based on the assumption that, although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor.”).

<sup>199</sup> *Id.* (“The diagnostic criteria for PTSD were revised in DSM-III-R in 1987, the DSM-IV in 1994, and again in the DSM-IV-TR in 2000. A very similar syndrome is classified in The Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines.”).

<sup>200</sup> *Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) Hazardous Exposures*, UNITED STATES DEP’T OF VETERANS AFFAIRS, <http://www.publichealth.va.gov/exposures/oefoif/index.asp> [hereinafter “OEF”] (“Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom (primarily in Iraq) are military campaigns that are part of the Overseas Contingency Operation. Operation Enduring Freedom (OEF) began in October 2001”).

<sup>201</sup> See The Associated Press, *The War in Afghanistan: A Timeline*, CBS NEWS (Dec. 1, 2009), <http://www.cbsnews.com/stories/2009/12/01/ap/government/main5850224.shtml>.

thousand.<sup>202</sup> That same year, the United States would have ten thousand troops stationed in Afghanistan.<sup>203</sup>

In 2003, President George W. Bush gave Iraqi leader Saddam Hussein and his sons forty-eight hours to leave the country or face the threat of war.<sup>204</sup> When Saddam and his sons did not leave, the United States led an invasion on Baghdad as President Bush assured the American people that the invasion's purpose was "to disarm Iraq, to free its people, and to defend the world from grave danger."<sup>205</sup> The American invasion toppled Saddam Hussein's government and marked the beginning of years of conflict in Iraq.<sup>206</sup> March of 2003 also marked the beginning of Operation Iraqi Freedom.<sup>207</sup>

Since 2001, approximately 1.64 million American troops have been deployed as part of OEF in Afghanistan and OIF in Iraq.<sup>208</sup> Today, the United States government, under President Barak Obama, has begun withdrawing troops from the Middle East. The Obama administration planned on having all troops out of Iraq by January of 2012.<sup>209</sup> On December 18, 2011, the last convoy of American troops in Iraq left the Middle East and began their voyage home.<sup>210</sup> The Obama Administration had also planned to pull 33,000 of the over 100,000 troops in Afghanistan by the end 2011.<sup>211</sup> Although many of the troops in Afghanistan have

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<sup>202</sup> *Id.*

<sup>203</sup> *Id.*

<sup>204</sup> *Iraq Profile*, BBC NEW MIDDLE EAST, <http://www.bbc.co.uk/news/world-middle-east-14546763> (last updated Feb. 5, 2013, 9:45AM).

<sup>205</sup> Jesse Singal, *Seven Years in Iraq: An Iraq War Timeline*, TIME (Mar. 19, 2010), [http://www.time.com/time/specials/packages/article/0,28804,1967340\\_1967342\\_1967398,00.html](http://www.time.com/time/specials/packages/article/0,28804,1967340_1967342_1967398,00.html).

<sup>206</sup> *See Iraq Profile*, *supra* note 204.

<sup>207</sup> *See Operations Enduring Freedom*, *supra* note 200. ("Operation Iraqi Freedom (OIF) began on March 20, 2003, and continued until 2010, when Operation New Dawn began, reflecting a reduced U.S. role in Iraq.").

<sup>208</sup> *See INVISIBLE WOUNDS OF WAR*, *supra* note 17, at xix.

<sup>209</sup> *See U.S. Forces Begin Withdrawal from Iraq*, WASH. POST (Nov. 2, 2011), [http://www.washingtonpost.com/world/us-forces-begin-withdrawal-from-iraq/2011/11/02/gIQAY3qMgM\\_video.html](http://www.washingtonpost.com/world/us-forces-begin-withdrawal-from-iraq/2011/11/02/gIQAY3qMgM_video.html).

<sup>210</sup> *See Last Convoy of American Troops Leaves Iraq*, N.Y. TIMES (Dec. 18, 2011), <http://www.nytimes.com/2011/12/19/world/middleeast/last-convoy-of-american-troops-leaves-iraq.html?pagewanted=all>.

<sup>211</sup> *See* Deb Riechmann & Slobodan Lekic, *Withdrawal from Afghanistan: 40,000 Troops to Leave War Zone by End of 2012*, HUFFINGTON POST (Nov. 29, 2011), [http://www.huffingtonpost.com/2011/11/29/withdrawal-from-afghanistan\\_n\\_1117972.html](http://www.huffingtonpost.com/2011/11/29/withdrawal-from-afghanistan_n_1117972.html).

returned home, many still remain. Because of the large number of troops still remaining in Afghanistan, the Senate recently voted to accelerate troop withdrawal in November of 2012.<sup>212</sup> The Senate hopes that the President will, “continue to draw down United States troop levels at a steady pace through the end of 2014; and end all regular combat operations by United States troops by no later than December 31, 2014, and take all possible steps to end such operations at the earliest date consistent with a safe and orderly draw down of United States troops in Afghanistan.”<sup>213</sup> Naturally, with the influx of troops returning home in the coming years, issues of coverage for PTSD treatment will certainly arise.

Due in part to the fact that the American public has had more access to international news through the media than it did in the past and also because soldiers are facing, once again, new methods of warfare, the current conflicts in the Middle East have marked an enormous increase not only in the number of soldiers affected with PTSD but also with the amount of national attention and healthcare services the disorder has received. Deployments to the Middle East have taken place at the quickest speed in the history of all volunteer forces with deployments lasting longer, common redeployments, and infrequent breaks in between deployments.<sup>214</sup> As America saw in both World War II and Vietnam,<sup>215</sup> recent advances in medical science, body armor and other military technology means that more soldiers are surviving experiences that would have killed them in earlier wars.<sup>216</sup> As the co-director of the “Invisible Wounds of War” Study team commented, however, “casualties of a different kind have emerged in large numbers—invisible wounds, such as post traumatic stress disorder.”<sup>217</sup> In the same study, a telephone survey of approximately two thousand previously deployed veterans were questioned and of those interviewed, fourteen percent reported symptoms consistent with major depression while another fourteen percent reported symptoms consistent with PTSD.<sup>218</sup> Applying these findings to the 1.64 million troops who had been deployed for either OEF or OIF as of October 2007, the study

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<sup>212</sup> See Traci G. Lee, *Senate Votes to Accelerate Troop Withdrawal from Afghanistan*, MSNBC (Nov. 29, 2012), <http://tv.msnbc.com/2012/11/29/senate-votes-to-accelerate-troop-withdrawal-from-afghanistan/>.

<sup>213</sup> *Id.*

<sup>214</sup> See INVISIBLE WOUNDS OF WAR, *supra* note 17, at xix.

<sup>215</sup> *Infra* pp. 86, 94.

<sup>216</sup> See INVISIBLE WOUNDS OF WAR, *supra* note 17, at xix.

<sup>217</sup> *Id.*

<sup>218</sup> See *id.* at 434 (nine percent of veterans reported symptoms consistent with both PTSD and major depression).

estimated that approximately 300,000 veterans were suffering from PTSD or major depression as of April 2008.<sup>219</sup>

The National Center for PTSD also found that ten to eighteen percent of OEF and OIF troops were likely to have PTSD upon returning home.<sup>220</sup> In assessing the stressors faced in each combat zone in 2003, the Center found that soldiers and marines reported more combat stressors at higher levels than soldiers in Afghanistan.<sup>221</sup> The Center listed certain factors which made it more likely that OEF or OIF service members would develop PTSD, which included longer deployment time, more severe combat exposure such as deployment to “forward” areas close to the enemy or seeing others wounded or killed, more severe physical injury, traumatic brain injury, not being married, and low morale and poor social support within the unit.<sup>222</sup>

### C. COVERAGE AND TREATMENT FOR VETERANS

The Department of Veterans Affairs now has an ever-expanding web of resources on coverage and services for veterans with mental health problems like PTSD. A quick glance at the Department’s website provides page upon page of information, resources, and additional informative documents such as informational pamphlets, a Guide to VA Mental Health Services for Veterans & Families, recent studies on veterans with mental disorders, and links to additional resources beyond those on the website itself.<sup>223</sup> The National Center for PTSD is also an excellent resource for veterans.<sup>224</sup> Programs like AboutFace, which details real veterans’ battles with PTSD, have made it apparent that the disorder is personal, extremely real, and curable with the right treatment.<sup>225</sup>

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<sup>219</sup> *Id.* at xxi.

<sup>220</sup> See *Mental Health Effects of Serving in Afghanistan and Iraq*, U.S. DEP’T OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/public/pages/overview-mental-health-effects.asp>.

<sup>221</sup> *Id.*

<sup>222</sup> *Id.* (Other factors included lower rank, lower level of schooling, family problems, member of the National Guard or Reserves, prior trauma exposure, female gender, and Hispanic ethnic group).

<sup>223</sup> See generally *U.S. Dep’t of Veterans Affairs*, U.S. DEP’T OF VETERANS AFFAIRS, [www.va.gov](http://www.va.gov).

<sup>224</sup> See generally *National Center for PTSD*, U.S. DEP’T OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/index.asp>.

<sup>225</sup> See generally *About Face*, U.S. DEP’T OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/apps/AboutFace/>.

The National Center for PTSD found that recent veterans are seeking health care from the DVA more than ever before.<sup>226</sup> DVA data indicates that between the years of 2002 to 2009, one million troops had left active duty in either Afghanistan or Iraq and thus became eligible for DVA care.<sup>227</sup> Of those one million troops, forty-six percent used DVA health care services and of those who used the services, forty-eight percent were diagnosed with a mental illness.<sup>228</sup> The Center did express concern, however, that many veterans with mental health problems had not yet accessed any available services.<sup>229</sup> Some possible reasons for failing to do so include concern over being seen as weak or treated differently, concern that others would lose confidence in them, concerns about privacy and side effects of treatments, and problems with access, such as cost or location of treatment.<sup>230</sup>

Today, veterans who have served or are currently serving in Iraq or Afghanistan may enroll in the DVA Health Care System and receive healthcare for two years after separation without any co-payment requirements for health issues that are related to military service.<sup>231</sup> After the two-year period expires, veterans may continue to utilize the DVA system but are required to pay applicable co-payments.<sup>232</sup> Although several laws have been proposed to extend the two-year period of time,<sup>233</sup> the DVA, in a 2005 hearing on the proposed laws, expressed its opposition to the laws claiming that two years was more than enough time to apply for enrollment in the health care system and to receive co-payment free health care.<sup>234</sup> When Congress expressed concern that such restriction may prevent veterans from enrolling in the DVA's health care program since symptoms in illnesses such as PTSD may not manifest until years after the trauma, the DVA responded by claiming that, "if PTSD appears in a non-enrolled combat veteran following the end of his or her two-year period of eligibility, and is subsequently determined to be service-connected, that veteran would then become eligible for enrollment in Priority Group 1, 2, or 3, and thus they would be able to receive needed care."<sup>235</sup>

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<sup>226</sup> See *Mental Health Effects*, *supra* note 220.

<sup>227</sup> *Id.*

<sup>228</sup> *Id.*

<sup>229</sup> *Id.*

<sup>230</sup> *Id.*

<sup>231</sup> See PANANGALA, *supra* note 186, at 20.

<sup>232</sup> *Id.*

<sup>233</sup> *Id.*

<sup>234</sup> *Id.*

<sup>235</sup> *Id.* at 21.



According to the DVA, it has come a long way in providing services for veterans with PTSD.<sup>236</sup> In addition to the DVA's efforts, the Assured Funding for Veterans Health Care Act of 2005, would require the Secretary of the Treasury to make mandatory appropriations for DVA health care.<sup>237</sup> Enacting the 2005 Act would result in a net increase in direct spending of approximately \$179 billion over the 2007-2010 period, and an additional \$518 billion over the 2007-2015 period.<sup>238</sup> More recently in 2010, President Barak Obama signed the Caregivers and Veterans Omnibus Health Services Act of 2010 into law.<sup>239</sup> Section 202 of the act specifically provides for training and certification of mental health care providers within the DVA for veterans suffering from sexual trauma or PTSD.<sup>240</sup>

The above series of acts, bills and laws proves that the American government has finally moved veterans' mental health closer to the top of its priority list. Unfortunately, many veterans are still left without adequate coverage for their mental health care. As a result, these veterans are receiving either inadequate treatment or no treatment at all for the PTSD that plagues them. Veterans' support systems that *are* in place are consistently experiencing funding cuts as well. For example, most recently, the DVA announced that it will no longer fund service dogs for veterans

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<sup>236</sup> *Id.* at 23 (pointing out that it has developed an Iraqi War guide for clinicians; implemented a national clinical reminder to prompt clinicians to assess OEF and OIF veterans for PTSD, depression, and substance abuse; implemented a national system of 144 specialized PTSD programs in all states; required all DVA outpatient clinics to either have a psychiatrist or psychologist on staff full-time or ensure that veterans can consult a mental health provider in their community; and established uniform budgets for mental health care at some of the DVA's health centers. In June 2004, the VA instituted the "Afghan and Iraq Post-Deployment Screen" as a mandatory electronic clinical reminder to conduct brief, post-deployment screening of OEF/OIF veterans. The screening consists of brief, validated screening measures to assess alcohol use, PTSD, and depression.).

<sup>237</sup> *Id.* at 26-27.

<sup>238</sup> *Id.* at 27.

<sup>239</sup> See Caregivers and Veterans Omnibus Health Services Act of 2010, PUB. L. NO. 111-163, 124 Stat. 1130 (2010). See also General James Jones, *Improving Health Care for Veterans*, THE WHITE HOUSE BLOG (May 6, 2010, 4:54 PM), <http://www.whitehouse.gov/blog/2010/05/05/improving-health-care-veterans> (for a summary of the Act).

<sup>240</sup> See Caregivers and Veterans Omnibus Health Services Act of 2010, PUB. L. NO. 111-163, 124 Stat. 1130, sec. 202 (2010).

with mental disorders like PTSD.<sup>241</sup> Endless news articles detail the plight these veterans face and their inability to secure the health care they deserve.<sup>242</sup> In 2009, two non-profit organizations, the Veterans for Common Sense and the Veterans for Truth, sought injunctive and declaratory relief concerning the delays in the DVA's mental health system and in the adjudication or service-connected death and disability compensation claims.<sup>243</sup> In 2011, the United States Court of Appeals for the Ninth Circuit found for Veterans in holding that the DVA's delays were a violation of veterans' due process rights to receive the benefits they're promised by the statute for harms and injuries sustained while in service.<sup>244</sup> Several months after the Ninth Circuit's holding, the DVA had still failed to take any measures to ameliorate the situations veterans with post-traumatic stress disorder are placed in.<sup>245</sup> Although the DVA claims it is taking more steps to improve its mental health care system, these measures are often still not enough.<sup>246</sup>

In addition to mounting pressures placed upon the DVA to overhaul its mental health system, courts and communities across the United States have pulled together more than ever before to support their troops. A new Veterans' Court in Queens, New York hears cases concerning veterans who have committed low-level misdemeanors while experiencing mental health or substance abuse problems.<sup>247</sup> The Veterans' Court will seek treatment rather than imprisonment for veteran-defendants and will also aim to assign a veteran mentor to each defendant in the hopes

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<sup>241</sup> See Kevin Dolak, *VA Cuts Funding for Service Dogs for PTSD Veterans*, ABC (Sept. 8, 2012), <http://abcnews.go.com/US/va-cuts-funding-service-dogs-ptsd-veterans/story?id=17179680#.UOc0XKWpV95>.

<sup>242</sup> See Erica Goode, *Suicide's Rising Toll: After Combat, Victims of an Inner War*, N.Y. TIMES (Aug. 1, 2009), <http://www.nytimes.com/2009/08/02/us/02suicide.html>; Suran, *supra* note 16.

<sup>243</sup> See Veterans for Common Sense & Veterans for Truth v. Shinseki, No. 08-16728, (9th Cir. May 10, 2011).

<sup>244</sup> *Id.*

<sup>245</sup> See *More Excuses and Delays from the VA*, N.Y. TIMES (Aug. 21, 2011), [http://www.nytimes.com/2011/08/22/opinion/more-excuses-and-delays-from-the-va.html?\\_r=1&ref=posttraumaticstressdisorder](http://www.nytimes.com/2011/08/22/opinion/more-excuses-and-delays-from-the-va.html?_r=1&ref=posttraumaticstressdisorder).

<sup>246</sup> See *While Veterans Wait*, N.Y. TIMES (Oct. 24, 2011), <http://www.nytimes.com/2011/10/25/opinion/while-veterans-ait.html?ref=posttraumaticstressdisorder>.

<sup>247</sup> See John Eligon, *Queens Court for Veterans Aims to Help, Not Punish*, N.Y. TIMES (Dec. 13, 2010), <http://www.nytimes.com/2010/12/14/nyregion/14vets.html>.

of establishing a meaningful connection.<sup>248</sup> Local community projects such as the Wounded Warrior Project have visions of fostering “the most successful, well-adjusted generation of wounded service members in our nation's history.” The Wounded Warrior Project does so by creating a support network for its local troops in their transition to civilian life, which may assist the veterans in seeking services such as mental health care coverage and treatment.<sup>249</sup> Such support means that veterans are returning home to more stable support systems than in previous wars. Unfortunately, what services currently exist are simply not able to provide enough support for the large number of veterans who need assistance.

## VII. CONCLUSION

The manifestation of post-traumatic stress disorder during each war's era was directly affected not only by the way in which society viewed mental illness at the time, but the way in which each war was fought. Advances in weaponry and medical technology meant that soldiers were seeing more horrific events take place and living to tell the tale. Upon returning home, the way in which soldiers were greeted by their fellow Americans not only affected the ways in which soldiers experienced post-traumatic stress disorder but also affected the ways in which the American government provided—or failed to provide—government-sponsored mental health coverage. When mental health was an afterthought in society's mind, it became so for the Department of Veterans Affairs. Advances in research in the world of mental health subsequently lead to a greater understanding of the origins and composition of mental disorders. The desire the world once had to bifurcate physical disorders from illnesses that plagued one's mind had blurred and the people of the United States slowly began to understand that one couldn't necessarily separate the two. Finally, as soldiers returned home to a more supportive society, the American government began to follow suit in increasing the duration and number of benefits that veterans would receive after completing their service.

The evolution of PTSD in veterans throughout the twentieth and twenty-first centuries coincided with the immense growth of the Department of Veterans Affairs. From offering simple pensions centuries before World War I to offering health care, loan, education *and*

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<sup>248</sup> *Id.*

<sup>249</sup> *See* THE WOUNDED WARRIOR PROJECT, <http://www.woundedwarriorproject.org/> (last visited Dec. 21, 2011).

employment programs today, the Department of Veterans Affairs has certainly come a long way from its inception. While the name and the symptoms associated with PTSD changed with each war's time period, one thing has remained: veterans are not receiving enough coverage, adequate treatment or adequate compensation for the traumatic mental injuries they have sustained while serving their country. Until the United States' Department of Veterans Affairs begins providing the coverage veterans deserve, affected veterans will not seek out the mental health care they need to successfully treat post-traumatic stress disorder.



# **A BILLION DOLLAR PROBLEM: THE INSURANCE INDUSTRY’S WIDESPREAD FAILURE TO ESCHEAT UNCLAIMED DEATH BENEFITS TO THE STATES**

DEVIN HARTLEY\*

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*This note examines whether insurers are violating state unclaimed property statutes as well as unfair claims settlement practices statutes by failing to take affirmative steps to locate and pay beneficiaries of life insurance policies or, in the alternative, by failing to escheat the proceeds to the state. This note shows that the current claims settlement practices of the nation’s largest insurers do indeed violate these statutes. Specifically, the insurance industry has used the Social Security Administration’s Death Master File (DMF) to identify deceased annuitants and terminate annuity payments but has failed to use the same technology to identify deceased insureds and pay beneficiaries. Additionally, this note describes the industry’s reaction to the regulatory scrutiny of its claims settlement practices and predicts a paradigm shift with respect to those practices; that is, a shift from an industry that only pays beneficiaries upon the filing of a claim to an industry that proactively seeks to identify deceased insureds and pay out the insurance benefits associated with those deaths.*

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“I’m concerned that the [life] insurance industry is not holding up its end of the sacred bargain it struck with its clients when it issued life insurance policies in the first place.”<sup>1</sup>

Since its inception, the life insurance industry has been relied upon by consumers as an ameliorating corollary to a tragedy; a type of financial

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\* I would like to thank Professor Jill Anderson for her valuable feedback on this note- it is much appreciated.

<sup>1</sup> *Metropolitan Life Insurance Company's Practices and Procedures Relating to the Use of the Death Master File Data and Related Information: Hearing Before the Insurance Commissioner of the State of California*, 11 (Fl. 2011) [hereinafter *California MetLife Hearing*] (statement of Dave Jones, California Insurance Commissioner).

safety net to be cast in the unfortunate event of a loved one's death. For most people, a life insurance policy represents a hard-earned effort to provide their loved ones with some measure of financial support, or at the very least, a means by which to cover funeral expenses.<sup>2</sup> In many cases, the foundation for these policies has been laid through decades of premium payments, paid by the insured with the understanding that the insured's heirs would one day reap the rewards.<sup>3</sup> Currently, however, there are widespread practices among the insurance industry which suggest that this understanding on the part of the consumer may be mistaken.

Specifically, it has been estimated that over 1 billion dollars in death benefits currently sit on the books of insurers,<sup>4</sup> unclaimed by the very beneficiaries that the insurer sought to protect, notwithstanding the fact that the industry has available to it the technology that would allow it to identify and reach out to those beneficiaries.<sup>5</sup> The situation is made more egregious by the fact that insurance companies regularly employ such technology to terminate annuity payments while failing to use this same technology to identify beneficiaries and pay death benefits.<sup>6</sup> Unfortunately, many of these same beneficiaries are further victimized when insurers rely on ambiguous contractual language to continue paying themselves premiums out of a policy's accumulated cash value long after

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<sup>2</sup> See Paul Sullivan, *Tracking Down and Collecting Unclaimed Life Insurance*, N.Y. TIMES, Feb. 25, 2011, available at <http://www.nytimes.com/2011/02/26/your-money/life-and-disability-insurance/26wealth.html>.

<sup>3</sup> See *id.* (“... most people expect the policies on which they have paid premiums for decades to help their heirs get by- or at the least cover funeral expenses”).

<sup>4</sup> Ed Leefeldt, *\$1 Billion in Life Insurance Unclaimed?*, MSN MONEY (May 19, 2011, 6:36 PM), available at <http://money.msn.com/saving-money-tips/post.aspx?post=f24dc3b4-e3a9-495d-8bcc-8be7fe5090ea>.

<sup>5</sup> See *California MetLife Hearing*, *supra* note 1, at 10 (statement of John Chiang, California State Controller).

<sup>6</sup> *Metropolitan Life Insurance Company: Hearing Before the Florida Office of Insurance Regulation*, 71-72 (Fl. 2011) [hereinafter *Florida MetLife Hearing*] (statement of Belinda Miller, Acting General Counsel, Florida Office of Insurance Regulation) (“Now you heard the issue is that . . . when the company is stopping payment, you use that file frequently and regularly; and then when it is a matter of paying someone a death benefit, it's later and not as consistent.”).

the insured has stopped making premium payments on that policy.<sup>7</sup> Once the policy's cash value is depleted, the insurer then lapses the policy without ever paying out death benefits.<sup>8</sup>

This note will examine whether some of the largest life insurers in the U.S. are violating state insurance statutes and state unclaimed property statutes by failing to take affirmative steps to pay out on policies of life insurance or, alternatively, escheat the proceeds to the appropriate state. Part I of this note discusses the problem of unclaimed death benefits by providing statistics detailing just how significant this issue has become while also touching on the process of demutualization, the smoking gun that helped uncover the true extent of the problem. Part II discusses the legal basis for the concept of escheat and traces the development of escheat law from its early English common law roots through landmark twentieth century Supreme Court cases and up to the current version of escheat as it appears in modern unclaimed property laws. Part III examines insurance industry practices<sup>9</sup> such as the asymmetrical use of the Death Master File and the misapplication of contractual anti-forfeiture provisions, practices

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<sup>7</sup> *In Re: Nationwide Insurance Company: Hearing Before the Florida Office of Insurance Regulation*, 36 (Fl. 2011) [hereinafter *Florida Nationwide Hearing*] (statement of Belinda Miller, Acting General Counsel, Florida Office of Insurance Regulation) ("But a lot of these policies aren't going to get to limiting age because they lapsed, because they [the insurers] paid the premium out of the accumulated cash in the policy and then it never gets to limiting age.").

<sup>8</sup> *Id.*

<sup>9</sup> It is important to note the extent to which the issues and practices discussed in this note truly are endemic to the insurance industry as a whole. This is not a situation where a few isolated insurers are acting as outliers, but rather, one where the majority of the nation's largest insurers are, to some degree, exhibiting these practices. For evidence of the pervasiveness of these practices within the insurance industry, one need look no further than the breadth and scope of the regulatory agreements that have already been entered into between regulators and insurers regarding the insurers' unclaimed property practices. MetLife, John Hancock, Prudential, AIG and Nationwide have all entered into regulatory agreements- and it is likely that others will soon follow; see Jack McDermott & Amy Bogner, *Florida Announces a \$11 Million Multi-Agency Agreement with the AIG Companies to Protect Life and Annuity Beneficiaries*, FLA. OFFICE OF INS. REG. (Oct. 22, 2012), <http://www.floridareg.com/PressReleases/viewmediarelease.aspx?id=1976>. See also *The Probe Into Life Insurance Company Beneficiary Payouts*, GO INSURANCE RATES (Aug. 25, 2011), <http://www.goinsurancerates.com/life-insurance/probe-into-life-insurance-company-beneficiary-payouts>.



which contribute to the industry's failure to pay out death benefits, or alternatively, escheat them to the state.<sup>10</sup> Part IV examines industry wide violations of state unclaimed property laws stemming from the failure of insurers to adhere to statutory dormancy requirements. Part V discusses the extent to which industry practices such as the asymmetrical use of the DMF constitute violations of state unfair claims practices law in the wake of *Connecticut Mutual v. Moore*.<sup>11</sup> Part VI of the note examines recent developments concerning the insurance industry's unclaimed property practices and its concomitant failure to pay out or escheat unclaimed death benefits. And finally, the note concludes by predicting that, due to regulatory pressure, the insurance industry as a whole is trending towards a reformed model of business that utilizes a more proactive approach with respect to locating beneficiaries, paying out death benefits, and escheating unclaimed benefits to the state.

## I. UNCLAIMED DEATH BENEFITS UNDER LIFE INSURANCE POLICIES: THE INDUSTRY WIDE DILEMMA

### A. THE EXTENT OF THE PROBLEM

According to life insurers, approximately 1% of death benefits owed to beneficiaries are never claimed.<sup>12</sup> Even with only 1% of policies going unclaimed, however, the total value of unclaimed death benefits figures to

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<sup>10</sup> See *California MetLife Hearing*, *supra* note 1, at 6 (statement by California Insurance Commissioner Dave Jones that "[s]ome insurers appear to use Death Master to cut off payments on annuities when an annuity owner dies, but do not use that information to identify life insurance policyholders who die and pay their beneficiaries.").

<sup>11</sup> *Conn. Mut. Life Ins. Co. v. Moore*, 333 U.S. 541 (1948).

<sup>12</sup> See e.g., *How to Find Lost Life Insurance Policies*, ARTICLESBASE.COM (May 25, 2007), <http://www.articlesbase.com/insurance-articles/how-to-collect-on-lost-life-insurance-policies-357858.html> ("Dave Potter, a spokesperson for Hartford Life said 'approximately less than 1% of all policies are never claimed by the beneficiary.'"); see also *California MetLife Hearing*, *supra* note 1, at 77-78 (statement of Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("If you looked over a period of time, about 99 percent of the claimed dollars paid came from the normal sources and about one percent of those claims never were submitted through the normal processes.").

be in the billions.<sup>13</sup> In terms of raw figures for unclaimed property around the country, it is estimated that roughly \$351 million in unclaimed life insurance was transferred to the states in 2009.<sup>14</sup> But perhaps even more telling is the \$1.3 billion in total unclaimed policy liability which is estimated to be on the books of the largest insurance companies.<sup>15</sup> New York has received \$400,287,736 in unclaimed life insurance property since 2000 and, out of that sum, has paid out \$64,772,228 to beneficiaries.<sup>16</sup> Since 1943, the state of New York has received \$10.5 billion in unclaimed property, only 20% of which is claimed in any given year.<sup>17</sup> Once the states are in possession of this unclaimed property, they are able to use these proceeds in a way that actually benefits the state's general population. For instance, California uses this extra source of revenue to alleviate budget shortfalls and supplement its general fund.<sup>18</sup> Yet, budget concerns and tax reduction aside, the state's main concern is returning the property to its rightful owner.<sup>19</sup> This goal is in stark contrast with the

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<sup>13</sup> Leslie Scism & Vauhini Vara, *Life Insurers Skimp on Payouts: States*, WALL ST. J. (Apr. 28, 2011), <http://online.wsj.com/article/SB10001424052748703367004576289423732099868.html>; Arthur D. Postal, *McCarty: Unclaimed Property Probe Could Bring in "North of \$1 Billion"*, LIFEHEALTHPRO (May 19, 2011), <http://edit.lifeandhealthinsurancenews.com/News/2011/5/Pages/McCarty-Unclaimed-Property-Probe-Could-Bring-in-North-of-1-Billion.aspx> (according to Florida Insurance Commissioner Kevin McCarty, an investigation into life insurers' death benefits payment practices could help beneficiaries and state unclaimed property funds recover "north of \$1 billion").

<sup>14</sup> Postal, *supra* note 13.

<sup>15</sup> Sullivan, *supra* note 2, at 2 (this is likely a conservative estimate as this data was drawn from a study performed by Joseph M. Belth, professor emeritus of insurance at Indiana University and editor of the Insurance Forum, which only considered the 20 largest insurance providers and their dealings with the 20 largest states); see Marc J. Musyl, Micah Schwalb & Sarah Niemiec Seedig, *Unclaimed Property Audits: No Laughing Matter*, NAT'L L. F. (Aug. 8, 2011), <http://nationallawforum.com/2011/08/08/unclaimed-property-audits-no-laughing-matter/>; see also Leefeldt, *supra* note 4.

<sup>16</sup> Paul Sullivan, *Tracking Down and Collecting Unclaimed Life Insurance*, N. Y. TIMES (Feb. 25, 2011), <http://www.nytimes.com/2011/02/26/your-money/life-and-disability-insurance/26wealth.html> (These figures were reported by Vanessa Lockel, a spokeswoman for the Office of the State Comptroller).

<sup>17</sup> *Id.*

<sup>18</sup> Scism & Vara, *supra* note 13.

<sup>19</sup> *Id.* at 2-3.

conduct of those insurers who hold onto unclaimed death benefits thereby allowing them to profit from the underlying investment income.<sup>20</sup> Certainly, insurers have incentives to escheat unclaimed death benefits in compliance with unclaimed property laws- namely to avoid having to pay the statutory interest on a late remittance<sup>21</sup>- but competing considerations, such as the profit insurers can realize by holding onto these benefits for years after the proceeds become due, are no doubt compelling.<sup>22</sup>

There are many reasons why this money goes unclaimed but the most prevalent seems to be the simple fact that the beneficiaries do not know the money exists.<sup>23</sup> Many cash-strapped states, intrigued by the magnitude of these figures, are now in the process of investigating the practices of life insurers with respect to unclaimed property. Specifically, they are looking into whether life insurers are doing enough to locate beneficiaries after a policyholder dies, and if they are complying with state laws which require insurers to turnover unclaimed money to the states.<sup>24</sup> Among other things, the states are attempting to ascertain what information life insurers have about their policyholders, whether the insurers are using this information properly and how vigilant the companies have been in attempting to track down beneficiaries. More specifically, they are looking to determine whether the insurers are using the DMF in a selective manner

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<sup>20</sup> *Id.*

<sup>21</sup> *Florida Nationwide Hearing*, *supra* note 7, at 42 (statement of Eric Henderson, Senior Vice President of Individual Investments, Nationwide) (“[I]f you just go for pure financial interest, it’s in our interest to do that [escheat] so we don’t have that statutory interest.”).

<sup>22</sup> *See California MetLife Hearing*, *supra* note 1, at 25 (statement of Adam Cole, General Counsel, California Department of Insurance) (“It should be noted that improper calculation of the dormancy period allows insurers unlawfully to retain millions of dollars in proceeds for years, if not decades, after they are due to be escheated.”).

<sup>23</sup> Sullivan, *supra* note 2, at 1 (Additional circumstances in which a policy may go unclaimed occur when the beneficiary dies before the policyholder, or when the beneficiary knows of the policy but is unable to locate it).

<sup>24</sup> Matthew Sturdevant, *Connecticut Joins Investigation into Unclaimed Life Insurance Funds*, COURANT.COM (Apr. 28, 2011, 3:52 PM), [http://blogs.courant.com/connecticut\\_insurance/2011/04/](http://blogs.courant.com/connecticut_insurance/2011/04/) (a total of 36 states, including Connecticut, New York, and all New England states, are now investigating life insurers’ actions in tracking down beneficiaries).

to avoid paying death benefits to policy beneficiaries.<sup>25</sup> Connecticut has been a recent addition to the growing list of states now in the midst of an investigation to uncover escheatable unclaimed property.<sup>26</sup> The states participating in the investigation view unclaimed property as a much needed source of revenue in the midst of budget shortfalls and trying economic times.<sup>27</sup> Additionally, from the insurer's point of view, failure to comply with these state unclaimed property laws could result in millions of dollars in interest and penalties being paid by the insurers.<sup>28</sup>

The unclaimed property figures, of course, raise the question: what happens to the billions of dollars of death benefits that go unclaimed? Unfortunately, this money is being used by insurers in ways that plainly disregard the state statutes governing unclaimed property.<sup>29</sup> When an insured stops paying the premiums on a policy, rather than turning to readily available information<sup>30</sup> to check whether the policyholder is

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<sup>25</sup> *Id.*

<sup>26</sup> *Id.* (Connecticut Insurance Commissioner Thomas B. Leonardi has announced that he is launching a "formal inquiry into the business practices of life insurance companies regarding timely payments of death benefits- money paid to a beneficiary when a policyholder dies.").

<sup>27</sup> Marc J. Musyl, et al., Unclaimed Property Audits: No Laughing Matter, THE NATIONAL LAW FORUM (Aug. 8, 2011), <http://nationallawforum.com/2011/08/08/unclaimed-property-audits-no-laughing-matter/> (In fact, during the last two years, some state legislatures have revised their unclaimed property statutes to reduce dormancy periods, which effectively speeds up the process by which states can receive and, ultimately, use this unclaimed property).

<sup>28</sup> *Id.*

<sup>29</sup> Although unclaimed property laws vary slightly on a state-by-state basis, most states use a modified version of one of the four Uniform Acts (Uniform Disposition of Unclaimed Property Act of 1954; Uniform Disposition of Unclaimed Property Act of 1966; Uniform Unclaimed Property Act of 1981; and the Uniform Unclaimed Property Act of 1995), which results in a baseline of uniformity among state unclaimed property laws; MICHAEL HOUGHTON, ESQ., ET AL., *Unclaimed Property*, in CORPORATE PRACTICE SERIES PORTFOLIO 74-2nd, A-1 (2006).

<sup>30</sup> See *Florida MetLife Hearing*, *supra* note 6 at 17-18 (statement of Belinda Miller, Acting General Counsel, Florida Office of Insurance Regulation) ("There are a variety of ways insurance companies become aware of [the] death of their insureds.... They [also] can use information contained in or derived from publicly available databases such as the Social Security Administration Death Master File.").

deceased, the insurer relies on so-called ‘anti-lapse’ or ‘nonforfeiture’ laws to pay itself premiums out of the built-up cash value of the policy.<sup>31</sup> The insurer continues to pay itself premiums until the cash value has been depleted, at which point it terminates the policy and avoids paying out any benefits.<sup>32</sup> Not only do the insurers fail to be proactive in terms of seeking out beneficiaries, they go so far as to use information on the United States Social Security Administration Death Master File [hereinafter DMF] to terminate annuity payouts yet ignore this exact same information on the life insurance side of their business.<sup>33</sup> The insurers regularly check the DMF for deceased annuitants because, when an annuitant dies, the insurers discontinue annuity payouts, but when it comes to life insurance policies, the insurers fail to utilize the DMF.<sup>34</sup> In other words, the insurance industry has embraced the practice of relying on the DMF when it is beneficial for them to do so, yet disregarding DMF information when its use would be to their detriment.

#### B. DEMUTUALIZATION: THE SMOKING GUN

During the early 2000’s many of the large insurers changed their form of ownership from a mutual company to a stock company.<sup>35</sup> A mutual insurance company is owned solely by the policyholders, whereas a stock insurance company is owned by members of the public. In order to accomplish this shift in ownership, they went through a process called “demutualization.” In that process the companies were required to compensate the policyholders for their interest in the mutual company with stock, or in some cases, cash. When the companies tried to locate those policyholders in order to compensate them it was determined that a large amount of those policy holders were missing, or “lost”. Prudential, for example, identified approximately 1 million policyholders as lost during

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<sup>31</sup> For a fuller discussion of the insurance industry’s questionable practices concerning anti-forfeiture provisions, *see infra* Part III, Section B.

<sup>32</sup> *See California MetLife Hearing, supra* note 1, at 6-7 (statement of Dave Jones, California Insurance Commissioner).

<sup>33</sup> *Id.* at 7 (statement of Dave Jones, California Insurance Commissioner).

<sup>34</sup> *Id.* (statement of Dave Jones, California Insurance Commissioner).

<sup>35</sup> *See California MetLife Hearing, supra* note 1, at 26 (statement of Dave Jones, California Insurance Commissioner).

their demutualization process<sup>36</sup> and Metropolitan Life, or MetLife, identified lost policyholders in excess of 1 million.<sup>37</sup> The companies recognized that the payment owed to these lost policyholders constituted unclaimed property and escheated those proceeds to the states pursuant to each state's unclaimed property laws.<sup>38</sup> Nevertheless, most companies<sup>39</sup> failed to investigate whether some of the policyholders who were lost, were lost because they were dead.<sup>40</sup> Because eligibility for a demutualization payment was conditioned upon the ownership of an underlying life insurance policy, each time a lost policyholder turned out to be deceased, death benefits were owed under the affiliated life insurance policy. To this end, regulators have been questioning insurers as to why they did not investigate whether these lost policyholders were dead, especially as some of the policies were over forty years old.<sup>41</sup> MetLife, for example, admitted that many of these policyholders were likely dead but could not explain why they failed to investigate which specific policies had benefits due.<sup>42</sup>

## II. UNCLAIMED PROPERTY STATUTES AND CASE LAW: THE PREVAILING INTERPRETATIONS

### A. THE CONCEPT OF ESCHEAT

The law of escheat has its roots in early English common law. The underlying philosophy of escheat was described by Blackstone: “[t]he

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<sup>36</sup> *Lost Life Insurance – Missing Policyholder Claims*, DEMUTUALIZATION CLAIMS CLEARINGHOUSE (Mar. 28, 2013), [www.demutualization-claims.com](http://www.demutualization-claims.com).

<sup>37</sup> See *California MetLife Hearing*, *supra* note 1, at 180 (statement of Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife).

<sup>38</sup> See *Lost Life Insurance – Missing Policyholder Claims*, *supra* note 36.

<sup>39</sup> Prudential being a notable exception, as they did, in fact, investigate whether these lost policyholders were dead.

<sup>40</sup> See *California MetLife Hearing*, *supra* note 1, at 183 (statement of Todd Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) (“Yeah. It’s probably reasonable to assume some were dead.”).

<sup>41</sup> *Id.* at 184 (statement of Dave Jones, California Insurance Commissioner); see *Florida MetLife Hearing*, *supra* note 6, at 127 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife).

<sup>42</sup> *Id.* at 184-85 (statement of Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife).

grand and fundamental maxim of all feudal tenure is this: that all lands were originally granted out by the sovereign, and are therefore holden, either mediately or immediately, of the crown.”<sup>43</sup> Early common law escheat was the concept by which land held by tenants was returned to the owner, or lord, in the event that a tenant died without an heir.<sup>44</sup> Escheat law, however, has evolved over time, and the modern concept refers to a process where the state takes title to property, real or personal, that is unclaimed or, in the language of many current statutes, presumed abandoned by the rightful owner.<sup>45</sup> Unclaimed property laws retained their original common law form until the 19<sup>th</sup> century when states began enacting the first escheat statutes. Rhode Island, Pennsylvania, Massachusetts, Ohio, Alabama, Illinois, Georgia, New Jersey, Mississippi, Missouri, Maryland and North Carolina were the first states to codify some version of the common law escheat doctrine.<sup>46</sup>

In early English common law, escheat referred only to real property, but the concept of *bona vacantia*, literally “vacant goods”, applied to personal property.<sup>47</sup> This concept allowed for the crown to take possession of personal property in the absence of any other rightful owner on the basis of its “royal prerogative.”<sup>48</sup> Remnants of *bona vacantia* can be found in modern statutory law where the state is allowed to acquire title to property that is presumed abandoned because “possession by the crown was more equitable than that of a stranger.”<sup>49</sup> Another rationale used to support the concept of *bona vacantia* was that the crown’s ownership would preclude conflicting claims made by private parties for the same property.<sup>50</sup>

The English common law doctrines of escheat and *bona vacantia* provide the foundation for current state unclaimed property laws.<sup>51</sup> American states have adopted as their unclaimed property laws a

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<sup>43</sup> HOUGHTON ET AL., *supra* note 29, at A-3.

<sup>44</sup> ANTHONY L. ANDREOLI & J. BROOKE SPOTSWOOD, UNCLAIMED PROPERTY: LAWS, COMPLIANCE, AND ENFORCEMENT 5 (2002).

<sup>45</sup> *Id.* at 5.

<sup>46</sup> HOUGHTON ET AL., *supra* note 29, at A-5.

<sup>47</sup> ANDREOLI & SPOTSWOOD, *supra* note 44, at 5.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> Michael I. Saltzman, *Providing Protection In State Unclaimed Property Audits*, in TAX ANALYSTS SPECIAL REPORT 1599, 1601 (2000).

combination of these two principles. In their current form, however, state escheat laws differ from the early English version in two significant aspects: first, the modern statutes presume all unclaimed property to be abandoned after it has remained unclaimed for a certain period of time; second, once the unclaimed property is escheated, the states act as the custodian of the property but not the owner.<sup>52</sup> The states hold the right to title against anyone except the missing owner, so, unlike its English predecessors, the state cannot claim absolute title to the property.<sup>53</sup> There are numerous justifications for the state serving as custodian of unclaimed property. For one, there is the fact that the state is a safer custodian of unclaimed property because businesses (such as insurance companies) could go bankrupt, or dissolve.<sup>54</sup> Also, there is the states' ability to better protect the interest of the owner, and the idea that a holder of unclaimed property should not benefit from property belonging to third parties.<sup>55</sup> Finally, state custody relieves the holder from any attendant liability while also preventing the possible misuse of funds by the holder.<sup>56</sup>

Current unclaimed property law, however, differs from the early common law concept of *bona vacantia* in that, at least in terms of intangible unclaimed property in the form of insurance policies, bank deposit accounts or dividend payments, it is not the possessor but rather the state who ultimately gains the right to these monies.<sup>57</sup> This divergence from early common law could be explained by the fact that the law of escheat originally applied only to real estate,<sup>58</sup> and additionally, in its earliest form, abandoned property was viewed mainly in terms of intentionally abandoned property.<sup>59</sup>

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<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> ANDREOLI & SPOTSWOOD, *supra* note 44, at 7 (discussing the underlying purpose of the 1954 Uniform Act and noting that although the Act was amended by future Uniform Unclaimed Property Acts, the rationale of this 1954 Act still applies).

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> Intangible unclaimed property includes items such as insurance policy proceeds, bank deposit accounts and dividend payments.

<sup>58</sup> HOUGHTON ET AL., *supra* note 29 at A-3.

<sup>59</sup> *Id.* at A-4.



## B. THE UNIFORM UNCLAIMED PROPERTY ACTS

Most states have adopted a version of one of the following uniform acts as their own unclaimed property law: the Uniform Disposition of Unclaimed Property Act of 1954, the Revised Uniform Disposition of Unclaimed Property Act of 1966, the Uniform Unclaimed Property Act of 1981 and the Uniform Unclaimed Property Act of 1995.<sup>60</sup> For the most part, unclaimed life insurance policy proceeds are escheatable three to five years after the policy becomes due and payable.<sup>61</sup> Both the 1981 Act and the 1995 Act are based on the original Uniform Unclaimed Property Act, which was proposed by the National Conference of Commissioners on Uniform State Laws [hereinafter NCCUSL].<sup>62</sup> The NCCUSL is a non-profit organization consisting of commissioners appointed by each state.<sup>63</sup> In 1954, the NCCUSL proposed the first uniform unclaimed property act, which became known as the Uniform Disposition of Unclaimed Property Act.<sup>64</sup> Thereafter, in 1966, the NCCUSL made small modifications to the 1954 Act and then again, in 1981, the NCCUSL made additional revisions.<sup>65</sup> The 1981 version is the version enacted by a majority of the states.<sup>66</sup> The 1995 Act, although it embodies the most recent revisions to the unclaimed property laws, has to this point been adopted by only a handful of states.<sup>67</sup>

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<sup>60</sup> UNIFORM UNCLAIMED PROPERTY ACT (1995); Saltzman, *supra* note 51, at 1602.

<sup>61</sup> See, e.g. CAL. CIV. PROC. CODE § 1515(a) (1990); CONN. GEN. STAT. § 3-65a (1958).

<sup>62</sup> ANDREOLI & SPOTSWOOD, *supra* note 44, at 29.

<sup>63</sup> *Frequently Asked Questions*, UNIFORM LAWS (March 28, 2013), <http://www.uniformlaws.org/narrative.aspx?title=Frequently%20Asked%20Questions>.

<sup>64</sup> *Why States Should Adopt UUPA*, UNIFORM LAWS (Mar. 28, 2013), <http://www.uniformlaws.org/narrative.aspx?title=Why%20States%20Should%20Adopt%20UUPA>.

<sup>65</sup> *Unclaimed Property Act Summary*, UNIFORM LAWS (Mar. 28, 2013), <http://www.uniformlaws.org/ActSummary.aspx?title=Unclaimed%20Property%20Act>.

<sup>66</sup> *Why States Should Adopt the UUPA*, *supra* note 64.

<sup>67</sup> *Id.*

## C. CONNECTICUT MUTUAL LIFE INSURANCE CO. v. MOORE

In *Connecticut Mutual Life Insurance v. Moore*, the U.S. Supreme Court ruled that administrative hurdles such as the requirement of a death certificate and the filing of a formal claim, although appropriate in the context of a contractual insurer-insured relationship, cannot be applied to the states.<sup>68</sup> The Court rejected the insurers' argument that a New York abandoned property statute was unconstitutional because Article I, section 10 of the Constitution prevents the state from transforming a contractual obligation that was previously only conditional into one that is liquidated.<sup>69</sup> The insurer's argument was predicated on the fact that their obligation to pay out policy proceeds to a beneficiary was triggered only upon proof of death or the filing of a formal claim. The New York statute in question, however, would require that insurers, once the dormancy period has run, escheat the proceeds of unclaimed policies to the states, irrespective of whether or not the insurers had received proof of death or a formal claim.<sup>70</sup> In rejecting the insurer's Contract Clause argument, the Court recognized the long-standing right of the state to collect abandoned property while also emphasizing the inherent unreasonableness of requiring the state, acting as a conservator rather than a contracting party, to comply with contractual obligations which may properly be imposed on the contracting parties.<sup>71</sup> The Court reasoned that "the state may more properly be custodian and beneficiary of abandoned property than any person," before pointing out that if these unclaimed benefits are not escheated to the state, the insurance companies would end up retaining money which they normally would have been required to pay out.<sup>72</sup> *Connecticut Mutual Life Insurance Co. v. Moore* reflects a preference towards the states, rather than the insurer, as the holder of unclaimed death benefits not only because the states are in a better position to track down

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<sup>68</sup> Conn. Mut. Life Ins. Co. v. Moore, 333 U.S. 541, 547 (1948).

<sup>69</sup> *Id.* at 545 ("[A]ppellants raised in their complaint and have consistently maintained that the statute impairs the obligation of contract within the meaning of Art. I, s 10, of the Constitution... Their argument under the Contract Clause is that the statute transforms into a liquidated obligation an obligation that was previously only conditional.").

<sup>70</sup> N.Y. ABAND. PROP. LAW § 703; *See also Moore*, 333 U.S. at 542 n.1.

<sup>71</sup> *Moore*, 333 U.S. at 547.

<sup>72</sup> *Id.* at 546.

the beneficiary but also because, until the beneficiary is located, the unclaimed proceeds are used to supplement the state's general fund.<sup>73</sup>

D. TEXAS V. NEW JERSEY

It is well settled in all jurisdictions that the state in which tangible property sits has the exclusive right and power to escheat.<sup>74</sup> However, with respect to intangible property such as life insurance benefits, the issue of which state holds the escheat right has historically been much less clear. Because the states themselves were powerless to decide a dispute between multiple states and there was no applicable federal statute, the burden of creating a rule fell on the Supreme Court. In 1965, the question of which state has the right to receive unclaimed intangible property when multiple states can assert ties to such property was settled in the case of *Texas v. New Jersey*.<sup>75</sup> In *Texas v. New Jersey*, four different states claimed title to various small debts owed by the Sun Oil Company to small creditors who had not come forward to claim them and could not be located.<sup>76</sup> Each state argued for the adoption of a different rule, but ultimately, the Court settled on the rule suggested by Florida that, because a debt is the property of the creditor as opposed to the debtor, "the right and power to escheat the debt should be accorded to the State of the creditor's last known address as shown by the debtor's books and records."<sup>77</sup> The Court reasoned that such a rule would eliminate the need to grapple with the often complicated legal concepts of residence and domicile while simplifying the administration

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<sup>73</sup> *Id.*

<sup>74</sup> *Texas v. New Jersey*, 379 U.S. 674, 677 (1965).

<sup>75</sup> *Id.* at 680-81.

<sup>76</sup> *Id.* at 675, 677 (Texas filed suit against New Jersey, Pennsylvania and the Sun Oil Company for injunctive and declaratory relief but Florida was permitted to intervene because they "claimed the right to escheat the portion of Sun's escheatable obligations owing to persons whose last known address was in Florida.").

<sup>77</sup> *Id.* at 678-81 (Texas argued that exclusive jurisdiction to escheat should be given to the State with the most significant 'contacts' with the debt; New Jersey urged the court to grant the right to escheat to the State that served as the domicile to the debtor; and finally, Pennsylvania asked the Court to hold that the right and power to escheat should be accorded to the location of the principal place of business of the corporate debtor.).

and application of escheat laws.<sup>78</sup> Also significant was that Florida's rule afforded proper weight to the fact that a debt is the property of the creditor, not the debtor.<sup>79</sup>

*Texas v. New Jersey* is particularly relevant to any discussion of the escheatment of unclaimed death benefits because, until the decision was handed down in 1965, there was no way to determine which state could properly lay claim to which unclaimed death benefits.<sup>80</sup> However, applying the *Texas v. New Jersey* holding to the context of unclaimed death benefits, it is well settled that the state in which the beneficiary was last known to reside is the state with the exclusive right to escheat the unclaimed death benefits owed to that beneficiary.<sup>81</sup>

### III. INSURANCE INDUSTRY PRACTICES

#### A. THE DEATH MASTER FILE

Unfortunately for the beneficiaries of insurance policies, insurance companies have failed to implement practices which would enable them to identify deceased insureds and pay out the insurance benefits associated with those deaths. In 1936, the Social Security Administration created the DMF for the purpose of providing the government, as well as multiple industries, with a tool to prevent fraud, verify death and ensure compliance with the USA Patriot Act. The DMF contains over sixty million records of death, each file containing information on the decedent's name, social security number, date of birth, date of death, state or country of residence, ZIP code of last residence and ZIP code of lump sum payment.<sup>82</sup> The DMF, despite being such a comprehensive database, is actually quite accurate in its information. In fact, Bill Gray, Deputy Commissioner of

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<sup>78</sup> *Id.* at 681.

<sup>79</sup> *Id.* at 680.

<sup>80</sup> See ANDREOLI & SPOTSWOOD, *supra* note 44, at 54-55.

<sup>81</sup> *Id.*

<sup>82</sup> It should be noted that the DMF may not contain this complete list of information for each decedent as, occasionally, the Social Security Administration itself does not possess all of this information. Mark E. Hill & Ira Rosenwaike, *The Social Security Administration's Death Master File: The Completeness of Death Reporting at Older Ages*, 64 SOC. SECURITY BULL. 45, 45-46 (2001-02).

Systems at the Social Security Administration, testified in a Congressional hearing that “the death data that we maintain is 99.5% accurate overall.”<sup>83</sup>

For the insurance industry, the DMF is a highly useful tool because it allows insurers to verify the deaths of policyholders and prevent identity fraud. There is evidence, however, that many insurance companies are using the DMF inconsistently. Regulators in multiple states have expressed concern that some of the nation’s largest insurance companies have embraced the practice of rigorously combing the information contained in the DMF when it benefits them to do so, yet altogether ignoring this same information when it would work to their detriment.<sup>84</sup> Insurers frequently run their annuitants against the DMF to ensure that annuity payments are promptly cut-off in the event of the annuitant’s death, yet their references<sup>85</sup> against the DMF are much less frequent on the life insurance side where a match would require death benefits to be paid to a beneficiary.<sup>86</sup> On the annuity side, life insurers benefit from the DMF by using it to learn of the death of an annuitant, thereby allowing the insurer to terminate monthly payouts owed to the annuitant. As a result of their access to the DMF, the insurers have information at their disposal which allows them to learn not only of annuitants who have passed away, but also life insurance policyholders who have passed away. Yet, they ignore this information on

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<sup>83</sup> *California MetLife Hearing*, *supra* note 1, at 21 (statement of Adam Cole, Gen. Couns. for the California Department of Insurance).

<sup>84</sup> *Id.* at 22-23.

<sup>85</sup> In this context, a ‘run against the DMF’ essentially amounts to a cross-check of all computer-recorded policies for any one particular branch of the business (annuities, life insurance, etc.) against the DMF, looking for matches.

<sup>86</sup> All annuity policies are in one of two phases: the pay-in or deferred stage, which is the time period during which the annuitant pays premiums on the policy, building up the policy’s savings without receiving any payments, and then the pay-out stage, where the annuitant no longer pays premiums and begins to receive monthly payments from the insurer which usually continue for the duration of the annuitant’s life. It is important to note that annuities in the pay-out phase are matched against the DMF with even greater frequency than annuities in the deferred phase because deferred annuities are not yet costing the insurer monthly premium payments so there is less urgency on insurers part to uncover DMF matches with respect to deferred annuities. *California MetLife Hearing*, *supra* note 1, at 46 (statement by Robert E. Sollmann, Jr., Executive Vice President, Retirement Products, MetLife) (“In general, these sweeps are conducted monthly for payout annuities and quarterly for deferred annuities.”).

the life insurance side, despite having already used this same information to terminate annuity payments.

In a May, 2011 hearing before the California Insurance Commissioner and the California State Controller, representatives from MetLife testified under oath to their practices and procedures relating to the DMF. It appears that this proceeding confirmed many of the regulator's concerns regarding the industry's asymmetrical use of the DMF. MetLife, which is currently the nation's largest insurance company in terms of asset size, revealed that, although they had access to the DMF in the late 1980's and began systematically running their group annuities policies against the DMF at that time,<sup>87</sup> it was not until 2007 that they first ran their life insurance policies against the DMF in any sort of comprehensive manner.<sup>88</sup> Additionally, it was not until 2010 that MetLife instituted policies and procedures to allow a DMF match on the annuities side to be communicated over to the life insurance side in an effort to determine whether this annuitant also had a life insurance policy.<sup>89</sup> Even then, MetLife admitted that the implementation of these new policies and procedures was at least partly due to investigations launched by state regulators into the industry's widespread practices in the area of unclaimed property.<sup>90</sup> When asked by state insurance commissioners at the investigative hearing to describe these newly instituted changes, none of

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<sup>87</sup> *Id.* at 35 (statement by Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("MetLife first began to use Death Master in the late 80's. That usage was primarily in our group annuity business.").

<sup>88</sup> *Florida MetLife Hearing, supra* note 6, at 49 (statement of Mr. Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("In 2007, we ran the death index against a majority of our individual life business..."); *Id.* at 152 (statement of Adam Hamm, Insurance Commissioner, North Dakota Insurance Department) (Hamm directed a question to a MetLife representative asking why MetLife's use of the DMF for annuities can be traced back to the 1980's but was not used for the first time on life insurance policies until 2007.).

<sup>89</sup> *California MetLife Hearing, supra* note 1, at 49 (statement of Robert E. Sollmann, Jr., Executive Vice President, Retirement Products, MetLife).

<sup>90</sup> *Florida MetLife Hearing, supra* note 6, at 87 (statement of Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("we were in discussions with regulators about this very topic, and I can assure you we are most interested in... what's on their minds... So I don't want to sit here and tell you that the discussion with our regulators wasn't part of that, too, because it was.").

the MetLife representatives were able to articulate what these policies and procedures, in fact, were.<sup>91</sup> Instead, MetLife requested to enter into the record a two page document that provided a “description of the processes” by which this information was shared between various business lines within the company.<sup>92</sup> Even now, insurers who have begun to run the DMF systematically across product lines still run their annuity policies against the DMF with much greater frequency than they do their life insurance policies. In fact, both MetLife and Nationwide have testified that, although they run all annuities in the pay-out phase against the DMF on a monthly basis, they run their life insurance policies against the DMF only once a year.<sup>93</sup> In other words, for every time these two insurers check the DMF for possible matches on the life insurance side, they perform twelve such checks on the annuities side. To provide further perspective, insurers first gained access to the DMF in the 1980’s. They began using the DMF on a monthly basis for annuities in the late 80’s, and they continue to use the DMF on a monthly basis for annuities.<sup>94</sup> Yet, some insurers<sup>95</sup> waited until the late 2000’s to first run their individual life insurance policies against the DMF, and it was not until 2010, in the wake of regulatory crackdowns, that they instituted any sort of systematic use of the DMF on the life insurance side.<sup>96</sup> Regulators have also pointed to the aggressive marketing

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<sup>91</sup> *California MetLife Hearing*, *supra* note 1, at 50 (statement of Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife).

<sup>92</sup> *Id.* at 51 (statement of Robert E. Sollmann, Jr., Executive Vice President, Retirement Products, MetLife).

<sup>93</sup> *Id.* at 129 (statement of Dave Jones, California Insurance Commissioner) (asking MetLife witnesses to explain the difference in frequency between DMF usage on the annuities side compared to the life insurance side); *Florida Nationwide Hearing*, *supra* note 7, at 20 (statement of Eric Henderson, Nationwide representative).

<sup>94</sup> *Id.*

<sup>95</sup> Prudential was the exception here as they ran their policies against the DMF for the first time shortly after their demutualization process concluded in 2002. *Reg. Settlement Agreement*, N.H. INS. DEPT. (Feb. 1, 2012), <http://www.nh.gov/insurance/consumers/documents/prsa.pdf>.

<sup>96</sup> *California MetLife Hearing*, *supra* note 1, at 49 (statement of Robert Sollmann, Jr., Executive Vice President, Retirement Products, MetLife) (when asked to provide the date at which MetLife first started using the DMF on a regular basis to identify matches on the life insurance side, Sollmann said: “Systematically on a more formal basis, we began that process within the last year.”).

and selling campaigns of insurers and expressed displeasure at certain insurers to the extent that their selective DMF use suggests a greater emphasis on selling products than on following through on the terms of these products once they are sold, by locating and paying beneficiaries the death benefits they are owed.<sup>97</sup>

When asked to account for their inconsistent use of the DMF across product lines, insurers have offered a variety of responses. First, they argue that the DMF is used on the annuity side to prevent expensive and time consuming<sup>98</sup> “duration errors”, errors where an annuitant who is no longer alive receives a payment in violation of the annuity contract.<sup>99</sup> Ironically, insurers are quick to point to the terms of the contract when, in a given situation, those terms call for the termination of payouts, but much more reticent to discuss contractual obligations in different circumstances where they may be required to pay out death benefits.<sup>100</sup> Easily lost in the argument that the DMF must be used more frequently for annuities to prevent duration errors is the fact that an insurer’s contractual right to stop annuity payments upon the death of an annuitant is no stronger than their obligation to pay out death benefits under a life insurance policy. If the DMF must be used frequently on the annuity side to avoid violating the

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<sup>97</sup> *Florida MetLife Hearing*, *supra* note 6, at 8 (statement by Kevin McCarty, Insurance Commissioner for the State of Florida) (“We know that life insurance companies work very hard to sign up people to purchase their products and accept billions of dollars a year in premium payments. We also know, based on information widely available in the public domain, that many beneficiaries go unpaid for a variety of reasons.”).

<sup>98</sup> It is important to note that these duration errors impose little to no burden on consumers, rather, it is only expensive and time consuming for the insurers to have to recoup these amounts.

<sup>99</sup> Under an annuity contract, the annuitant must be alive in order to receive the benefits. So, a duration error occurs when an annuity payment is sent out after the death of the annuitant. *California MetLife Hearing*, *supra* note 1, at 37-38 (statement of Todd B. Katz, Executive Vice President, U.S. Business Insurance Products, MetLife). In such a situation, the insurer would be within its rights to recover the amount incorrectly paid out. *Id.* at 129-30 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife).

<sup>100</sup> *Id.* at 129 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife) (“We believe that the frequency needs to consider the underlying contractual provisions and the promises that are embedded in those policies.”).



terms of the contract, then it should be used just as frequently on the life insurance side where the terms of the contract are no less clear and of equal weight. By saying that the DMF must be used more frequently for one than the other, the insurance industry is assigning greater value to contractual provisions which create a beneficial right for the company, and lesser to those provisions which create a liability for the company.

Perhaps even more inexplicable, however, is the insurers' argument that the DMF should be utilized less frequently on the life insurance side so that the insurance company does not interfere with the grieving process of the victim's family.<sup>101</sup> MetLife testified that one of the reasons for their sporadic use of the DMF for life policies was their belief that beneficiaries prefer to "take a little bit of time to get their loved one's affairs in order before they actually make a claim for life insurance benefits."<sup>102</sup> MetLife suggested that if they used the DMF as often on the life insurance side as they did on the annuities side, they would be "matching almost in real time" thereby inappropriately rushing grieving families into making a claim. However, the insurers have no problem "injecting themselves into that process"<sup>103</sup> when it comes to sending a letter to a deceased annuitant's family informing them that they will no longer be receiving annuity payments. In fact, MetLife and Nationwide, among others, have said it is their policy to send such a letter immediately following the death of an annuitant to inform the victim's family that, as a result of the annuitant's death, they will no longer be receiving annuity payments.<sup>104</sup> It did not take long for the regulators to pick up on these

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<sup>101</sup> *Id.* at 130-31 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife).

<sup>102</sup> *Id.*; *Florida MetLife Hearing*, *supra* note 6, at 77-78 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife) ("the practical reason is we don't want to insert ourselves into the process...[w]e believe that beneficiaries should be given an appropriate amount of time to get their loved ones' affairs in order.").

<sup>103</sup> *California MetLife Hearing*, *supra* note 1, at 131 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife).

<sup>104</sup> *Id.* at 37 (statement of Todd Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("[I]t certainly was used as a means to prevent duration errors by sending a letter of notification to an individual where we had an indication of death, advising that individual of such indication and that the payments were suspended."). *Florida MetLife Hearing*, *supra* note 6, at 34 (statement of Todd Katz, Executive Vice President, U.S. Business Insurance

inconsistencies. After hearing MetLife representatives testify to this effect, John Chiang, California State Controller, expressed his incredulity on the record when he stated: “But I don’t personally find it invasive if, in the event that somebody passed away, my family received notice that we may be the beneficiary of the proceeds.”<sup>105</sup> Additionally, the insurance industry has conducted no research on this matter and can provide no data to substantiate their claim that consumers would generally be opposed to hearing from insurers at this stage regarding potential death benefits.<sup>106</sup> Moreover, the very fact that insurance companies routinely send letters to annuitants’ families immediately following the annuitants death renders this supposed concern towards grieving families disingenuous at best.

#### B. ANTI-FORFEITURE PROVISIONS

Another issue of growing concern to state regulators is the insurance industry’s questionable practices relating to the anti-forfeiture provisions in life insurance contracts. Most life insurance policies contain a provision, designed to be a consumer protection tool, which allows for premiums to be paid automatically out of the built up cash value of a policy in the event that a premium payment is missed.<sup>107</sup> This becomes especially useful should an insured, for whatever reason, miss a monthly premium payment. Without the anti-forfeiture provision in the contract, one missed payment could result in the policy being terminated but, with it, the missed premium would automatically be paid out of the policy’s accrued cash value and the policy would remain in force.<sup>108</sup>

However, the insurance industry has been using these non-forfeiture provisions to pay themselves monthly premiums after an insured has died. The insurers continue to collect monthly premiums until the

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Products, MetLife) (“For a group annuity, we consider a match an indication of death. We suspend the annuity payment. We write to the family indicating that we have done that.”).

<sup>105</sup> *Id.* at 161.

<sup>106</sup> *California MetLife Hearing*, *supra* note 1, at 163 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife).

<sup>107</sup> *Id.* at 94 (statement of Todd Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) (Anti-forfeiture provisions may vary slightly by contract but, for the most part, the specific kind used by insurers to continue paying themselves premiums out of the policy’s built up cash value are commonly referred to as automatic premium loans, or APL’s.).

<sup>108</sup> *Id.*

policy's cash value has been depleted, at which point, the policy is allowed to lapse with no value.<sup>109</sup> The argument is also made by the insurers, again somewhat ironically, that the problem of incorrectly lapsed policies can be rectified by running a DMF match against all policies, both in force and lapsed, which would uncover any policy where the date of death preceded the date at which the policy lapsed.<sup>110</sup> Insurance companies have assured regulators that anytime a DMF match indicates an incorrectly lapsed policy they will restore the value of the policy to whatever it was at the time of the insured's death. However, even if insurers are able to identify these lapsed policies, restore the value and locate the beneficiaries, tasks which in themselves seem unlikely, this fails to offset what could be decades of waiting in the case of some beneficiaries.<sup>111</sup> MetLife testified that they ran lapsed policies from as far back as the mid-1960's in their 2007 DMF match, which means that even if those policies were restored to their proper value and the beneficiary was located, the death benefits would have been received more than forty years after the death of the insured.<sup>112</sup> Given this timeframe, it is not inconceivable that the beneficiary would have passed away long before receiving death benefits that were owed to him decades earlier. Regulators have uncovered this industry wide practice and expressed their disapproval: "Anti-forfeiture provisions are a consumer protection device. They should not be used to usurp the value of a policy after [an insured's] death or result in people not getting the proceeds of the policy when the person [the insured] has actually died."<sup>113</sup>

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<sup>109</sup> Both MetLife and Nationwide admitted this does occur with their policyholders although neither would provide a figure as to how frequently. *See id.* at 95 (statement of Todd Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("could there ever be a situation where an individual doesn't make a premium and there's cash value in that policy and the policy ultimately lapsed? That certainly could happen.").

<sup>110</sup> *Id.* at 95.

<sup>111</sup> 2007 was the first year in which life insurance policies were run against the DMF, so this would have been the earliest possible year which the insurers could have detected incorrectly lapsed policies. So, for all policies lapsed in the 90's or earlier, the waiting period for beneficiaries to receive their death benefits could be measured in decades.

<sup>112</sup> *Florida MetLife Hearing, supra* note 6, at 127 (statement of Frank Cassandra, Senior Vice President, Insurance Products Financial, MetLife).

<sup>113</sup> *Id.* at 21 (statement of Belinda Miller, Acting General Counsel, Florida Office of Insurance Regulation).

#### IV. INDUSTRY WIDE VIOLATIONS OF STATE UNCLAIMED PROPERTY LAW

Unfortunately, asymmetrical use of the DMF is not the only industry-wide practice which has come under regulatory fire of late. State Controllers and Treasurers throughout the country are looking into whether insurers are violating unclaimed property laws by holding onto abandoned funds long after they should have been escheated to the state.<sup>114</sup> Although many of these investigations are still in progress, an analysis of industry practices against the backdrop of unclaimed property statutes reveals that insurers may be violating these state laws.<sup>115</sup>

Perhaps the most glaring violation of unclaimed property law centers on the industry's interpretation and, ultimately, exploitation of the statutory dormancy period. As California Insurance Commissioner Dave Jones stated: "[I]mproper calculation of the dormancy period allows insurers unlawfully to retain millions of dollars in proceeds for years, if not decades, after they are due to be escheated."<sup>116</sup> Each state's unclaimed property laws reference a dormancy period, which is the length of time that property must remain unclaimed before it is considered abandoned and becomes escheatable to the State. Most dormancy periods are either three or five years. Florida, for example, has a five year dormancy period, whereas Connecticut, New Jersey and Indiana all have dormancy periods of three years.<sup>117</sup> For insurance companies, this means that any unclaimed death benefits must be escheated to the state once the dormancy period has run. With this in mind, the crucial question then becomes: what triggers the dormancy period? The insurers claim that the dormancy period does not begin to run until the beneficiary has provided them with a death certificate and a full claim has been filed.<sup>118</sup> This interpretation, however, runs

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<sup>114</sup> See *California MetLife Hearing*, *supra* note 1, at 25 (statement of Adam Cole, General Counsel, California Department of Insurance).

<sup>115</sup> See *infra* Part VI for a fuller discussion of these state led investigations of the insurance industry and recent regulatory developments relating to unclaimed property.

<sup>116</sup> *California MetLife Hearing*, *supra* note 1, at 25.

<sup>117</sup> CONN. GEN. STAT. § 3-58a (2011); FLA. STAT. § 717.107 (2005); IND. CODE § 32-34-1-20 (2010); N.J. STAT. ANN. § 46:30B-28.1 (West 2004).

<sup>118</sup> See *Florida MetLife Hearing*, *supra* note 6, at 154-55 (statement of Todd Katz, Executive Vice President, U.S. Business Insurance Products, MetLife) ("[I]n virtually all of our forms... proof of death is a requirement for a liability.").

counter to the Supreme Court ruling in *Connecticut Mutual v. Moore* where it was determined that contractual obligations, such as the filing of a claim, may properly be required of a beneficiary but are not appropriate when applied to the states.<sup>119</sup> The holding in *Moore* was essentially codified when Congress passed the Uniform Disposition of Unclaimed Property Acts. In fact, the 1981 Act contained a provision which stated: “Property is payable or distributable for the purpose of this Act notwithstanding the owner’s failure to make demand or to present any instrument or document required to receive payment.”<sup>120</sup> In their comment, the Commissioners described as the underlying purpose of this subsection “to make clear that property is reportable notwithstanding that the owner, who has lost or otherwise forgotten his entitlement to property, fails to present evidence of his ownership to the holder or to make a demand for payment.”<sup>121</sup>

The state unclaimed property laws, having derived almost exclusively from the Uniform Acts, closely mirror the language contained in those Acts. Most of the state statutes, for example, label the point at which a life insurance policy becomes “due and payable” as the start of the dormancy period.<sup>122</sup> Again, there is disagreement between the insurance industry and regulators as to what constitutes “due and payable.” The regulators maintain that a life insurance policy becomes so on the actual date of death of the insured.<sup>123</sup> The insurers assert that “due and payable” is the point at which a formal claim is made and a death certificate is

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<sup>119</sup> See *Conn. Mutual Life Ins. Co. v. Moore*, 333 U.S. 541, 547 (1948) (“When the state undertakes the protection of abandoned claims, it would be beyond a reasonable requirement to compel the state to comply with conditions that may be quite proper as between the contracting parties.”).

<sup>120</sup> UNIF. UNCLAIMED PROP. ACT § 2(b), 8C U.L.A. 185 (1981). Also, it is important to note that the beneficiary of a life insurance policy becomes the “owner” of the policy proceeds upon the death of the insured.

<sup>121</sup> ANDREOLI & SPOTSWOOD, *supra* note 44, at 231.

<sup>122</sup> CONN. GEN. STAT. § 3-58a (2011) (“As used in this section, “unclaimed funds” means all moneys held and owing by any insurance company unclaimed and unpaid for more than three years after the moneys became due and payable as established from the records of a life insurance company . . .”).

<sup>123</sup> *Florida Nationwide Hearing*, *supra* note 7, at 42 (statement of Belinda Miller, Acting General Counsel, Fla. Office of Ins. Regulation) (“[U]nder the Unclaimed Property Law you don’t necessarily need to have a death certificate certified from the beneficiary.”).

presented to the insurer.<sup>124</sup> If, for example, an insured died in 1992 but the insurer fails to run their policyholders against the DMF until 2010, depending on which interpretation of “due and payable” is used, there would be different outcomes as to when the property becomes escheatable. The insurers would likely construe “due and payable” to mean the date at which they learned of the death (2010), thereby allowing them to hold onto the funds for an additional three or five years.<sup>125</sup> The regulators would say that the policy proceeds became “due and payable” on the date of death of the insured (1992), which would mean the dormancy period would have long ago expired and the proceeds would be immediately escheatable to the state.

Given the large amounts of money at stake, the lack of case law directly addressing the “due and payable” issue is somewhat surprising. Nevertheless, the holding in *Moore*, the language of the Uniform Acts and the clear intent behind those Acts all lend support to the conclusion that a policy becomes “due and payable” on the date of death of the insured. This interpretation is bolstered by the fact that insurers now have access to the actual date of death of all policyholders through the DMF.<sup>126</sup> Also, as California State Controller John Chiang pointed out, the insurers definition of “due and payable” cannot be correct simply because, in many instances, it would result in the dormancy period never being triggered, thereby allowing insurers to retain unclaimed death benefits indefinitely.<sup>127</sup>

Also instructive in determining what constitutes “due and payable” for the purpose of triggering the dormancy period is a closer look at the underlying purpose of dormancy statutes in general. The dormancy period is the time during which the owner (the beneficiary of the policy) can come forward and claim his benefits. The problem with the industry argument that “due and payable” means the point at which the insurer receives a

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<sup>124</sup> See *California MetLife Hearing*, *supra* note 1, at 169 (statement of Frank Cassandra, Senior Vice President, Ins. Prods. Fin., MetLife) (“[W]ithout someone submitting a claim without the facts around the debt... that in and of itself may not be sufficient for the company to know it has a liability.”).

<sup>125</sup> This time period would depend on the state, as the dormancy period varies by state but is usually either three or five years.

<sup>126</sup> See *California MetLife Hearing*, *supra* note 1, at 35 (statement of Todd B. Katz, Exec. Vice President, US Bus. Ins. Prod., MetLife).

<sup>127</sup> *Id.* at 169 (statement of John Chiang, Cal. State Controller) (“Your view of when the obligation is triggered, the extreme... is that in certain instances, you would never have a triggering responsibility.”).

death certificate and a full claim is that it assumes the dormancy period is for the benefit of the holder, which it is not. The purpose of the dormancy period is to provide a time period, after the passing of which, it is presumed that the owner of the property—here, the beneficiary—has abandoned his property.<sup>128</sup> In light of this purpose, “due and payable” must mean the date of death of the insured because the beneficiary becomes the owner of the property upon the insured’s death.

#### V. INDUSTRY WIDE VIOLATIONS OF STATE UNFAIR CLAIMS PRACTICES LAW

On August 15, 2011 the National Association of Insurance Commissioners [hereinafter NAIC] formed a special task force to investigate a number of life insurance companies focusing on their settlement practices related to unclaimed death benefits and their handling of unclaimed property.<sup>129</sup> Presumably, the task force will be analyzing whether the failure to proactively identify deaths among policyholders and subsequently look for beneficiaries constitutes a violation of various state unfair insurance claims settlement practices. Whether the insurance industry is operating in violation of these unfair claims practices laws will depend heavily on regulators’ determinations regarding the industry’s use of the DMF.<sup>130</sup> As previously discussed, regulators have expressed concerns about the industry’s selective use of the DMF. Certainly, these ongoing investigations will look very closely into the DMF practices of the insurance industry. Florida Insurance Commissioner Kevin McCarty framed the issue of DMF usage within the context of unfair claims settlement practices when he stated: “We want to have a clear

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<sup>128</sup> See ANDREOLI & SPOTSWOOD, *supra* note 44, at 231 (discussing the Commissioners’ Comment to Section 2 of the 1981 Uniform Disposition of Unclaimed Property Act regarding the statistical evidence used to determine what length dormancy period provided the owner with the optimum chance to come forward and claim his funds).

<sup>129</sup> The following states are among those involved in the NAIC investigation: Alabama, Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Florida, Georgia, Indiana, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island and West Virginia.

<sup>130</sup> See *supra* Part III.A for a fuller discussion of the insurance industry’s practices relating to the DMF.

understanding of what is an appropriate claims-settlement practice. It is hard for me to get my arms around the concept that a company would use a database to terminate an annuity, but fail to use that same database to investigate whether a claim exists on a life policy.”<sup>131</sup>

It seems clear that the insurance regulators, acting under the authority of the newly formed NAIC task force, have the power to investigate and take action against those insurance companies who are acting in violation of state law. Most states, under their insurance laws, have adopted similar, if not identical, unfair insurance claims settlement practice acts.<sup>132</sup> For example, in California, an insurance company violates the Unfair Claims Practices Act if it “fail[s] to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.”<sup>133</sup> It is possible that any asymmetrical use of the DMF uncovered by the NAIC task force would fall within the scope of activities prohibited by unfair claims practice statutes.<sup>134</sup> California Insurance Commissioner Dave Jones hinted as much in the investigative hearing he led in May of 2011: “Let’s be perfectly clear. The insurance companies know about these policies, even if the beneficiaries don’t.”<sup>135</sup> To the extent companies have information in their books and records that allows them to identify deceased individuals but only use that

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<sup>131</sup> Scism & Vara, *supra* note 13.

<sup>132</sup> See CAL. INS. CODE § 790.03(h)(3) (2010) (“[f]ailing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies” constitutes unfair claims settlement practice); FLA. STAT. ANN. § 626.9541(1)(i)(3)(a) (West 2006) (“[f]ailing to adopt and implement standards for the proper investigation of claims” constitutes unfair claims settlement practice); 215 ILL. COMP. STAT. 5/154.6(c) (2010) (“[f]ailing to adopt and implement reasonable standards for the prompt investigations and settlement of claims arising under its policies” constitutes unfair claims settlement practice).

<sup>133</sup> CAL. INS. CODE § 790.03(h)(3) (2010).

<sup>134</sup> See *California MetLife Hearing*, *supra* note 1, at 10 (statement of John Chiang, Cal. State Controller) (“I was concerned that the life insurance industry was ignoring information that it had access to which would identify deceased clients and enable[d] the company to pay those benefits to either the insured’s beneficiaries or to the State of California so that we could return those benefits to the beneficiaries.”).

<sup>135</sup> *Id.* at 10.



information when it benefits them, an unfair claims settlement practice is implicated.

The issue of the insurance industry's use of the DMF is an area that is ripe for regulatory intervention. However, the question of whether the insurance companies' failure to properly interpret and follow state unclaimed property statutes amounts to a violation of unfair claims laws is not easily answered. It can be argued that the jurisdiction of the insurance regulators extends only to the prompt investigation and processing of claims arising under insurance policies and that, in the event no beneficiary has been located after a search, the companies have satisfied their obligation under those acts. Such a determination, while undoubtedly propounded by the insurance companies, does not adequately address the symbiotic relationship between the Unfair Insurance Claims Settlement Acts and the Unclaimed Property Acts.<sup>136</sup> The purpose of the Unclaimed Property Acts is not to enrich the treasuries of the states, as many insurers would argue, but rather to entrust money to the states in their role as *parens patriae* for citizens of those states.<sup>137</sup> The goal of these unclaimed property statutes is to get the unclaimed funds in the hands of the most able conservator; the conservator most likely to return the unclaimed funds to the rightful owner.<sup>138</sup> *Connecticut Mutual v. Moore* has decisively ruled that the state, and not the insurance company, is the conservator best suited for this important task: "The State may more properly be custodian and beneficiary of abandoned property than any person."<sup>139</sup> In effect, the Supreme Court held that, with respect to abandoned life insurance proceeds, the State must step into the shoes of the beneficiary until such

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<sup>136</sup> ANDREOLI & SPOTSWOOD, *supra* note 44, at 241 (The Commissioners' Comment for subsection (c) of Section 7 of the 1981 Uniform Disposition of Unclaimed Property Act explains "that proceeds of a life insurance policy are presumed abandoned if the insurer is aware that the insured has died even though actual proof of death has not been furnished to the insurer." This is similar in effect to provisions of unclaimed property acts that require insurers "to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under life insurance policies" as both call for a reasonable amount of due diligence on the part of insurers once they have knowledge of a claim or of an insured's death.).

<sup>137</sup> *Moore*, 33 U.S. at 546.

<sup>138</sup> *Id.* at 546.

<sup>139</sup> *Id.* at 546-47 ("The State is acting as a conservator, not as a party to a contract.").

time as the beneficiary comes forward to claim his or her policy proceeds. Viewed through the prism of *Connecticut Mutual v. Moore*, the insurance industry's failure to escheat unclaimed death benefits to the states, despite having information indicating that such benefits are due, may constitute a violation of unfair claims practices law.

## VI. RECENT DEVELOPMENTS

Beginning around 2008, various state treasurers and controllers joined in a multi-state audit of the John Hancock Life Insurance Company and Prudential Insurance Company, specifically for the purpose of identifying abandoned death benefits under policies of life insurance and annuities. On June 1, 2011, Hancock entered into what was termed a Global Resolution Agreement [hereinafter Hancock Agreement] with a list of states that now totals at least thirty-five.<sup>140</sup> On January 11, 2012, Prudential entered into a similar Global Resolution Agreement [hereinafter Prudential Agreement].<sup>141</sup> The Hancock and Prudential Agreements,

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<sup>140</sup> California State Controller John Chiang has made both Global Resolution Agreements (The Hancock Agreement and the Prudential Agreement) public on the California State Controller's Office Website under the press release section. *Controller Reaches Settlement with Insurer John Hancock and Settlement (Global Resolution Agreement)*, CALIFORNIA STATE CONTROLLER'S OFFICE (Apr. 22, 2011), [http://www.sco.ca.gov/eo\\_pressrel\\_9934.html](http://www.sco.ca.gov/eo_pressrel_9934.html) [hereinafter *Hancock Agreement*]. As of this date, the following states have signed on to the Hancock Agreement: Arizona, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington and Wisconsin.

<sup>141</sup> *Controller Reaches Settlement with Prudential Insurance and Multi-State Agreement (Global Resolution Agreement)*, CALIFORNIA STATE CONTROLLER'S OFFICE (Jan. 13, 2012), [http://www.sco.ca.gov/eo\\_pressrel\\_11429.html](http://www.sco.ca.gov/eo_pressrel_11429.html) [hereinafter *Prudential Agreement*]. As of this date, the following states have signed onto the Prudential Agreement: Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming.

entered into by state controllers and treasurers together with the insurers, are significant for multiple reasons. First, they provide that, for the purpose of the Agreements, the date of death of the insured begins the dormancy period.<sup>142</sup> This is a concession that accepts the regulator interpretation of the unclaimed property statutes that dormancy begins upon the death of the insured and not formal notice and proof of death as the insurance companies contended. Second, the Hancock and Prudential Agreements provide that the states will be free to audit the books and records of Hancock and Prudential going back to 1992 in an effort to determine if those books and records contain evidence of unpaid death benefits.<sup>143</sup> And finally, the Hancock and Prudential Agreements provide that, to the extent that abandoned death benefit proceeds are identified and escheated to the states, those proceeds will be escheated with 3% interest compounded annually from 1995 or date of death of the insured, whichever is later.<sup>144</sup> This interest component could arguably be considered a penalty for non-compliance with the state unclaimed property statutes notwithstanding the fact that the language of the Hancock and Prudential Agreements describes it simply as interest included on top of unclaimed death benefits when they are turned over to the states.<sup>145</sup>

On February 2, 2012, the NAIC Task Force, led by California, Florida, Illinois, New Hampshire, North Dakota, Pennsylvania and New Jersey, entered into a Regulatory Settlement Agreement which calls for Prudential to pay an assessment of \$17 million to state insurance departments.<sup>146</sup> Under the terms of this Agreement, Prudential must

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<sup>142</sup> See *Hancock Agreement*, *supra* note 140, at 9 (“The death benefit under life insurance policies shall be determined in accordance with the policy terms as of the date of death of the insured”); see also *Prudential Agreement*, *supra* note 141, at 11 (“Proceeds under life insurance policies shall be determined in accordance with the policy terms as of the date of death”).

<sup>143</sup> See *Hancock Agreement*, *supra* note 140, at 4; see also *Prudential Agreement*, *supra* note 141, at 6.

<sup>144</sup> See *Hancock Agreement*, *supra* note 140, at 9; see also *Prudential Agreement*, *supra* note 141, at 11.

<sup>145</sup> Most state unclaimed property statutes provide for interest and penalties for late reported property. See, e.g., FLA. STAT. ANN. § 717.134 (West 2010).

<sup>146</sup> The California Department of Insurance has made this regulatory agreement available under the press release section of their website by clicking on the link for ‘agreement.’ See “Death Master” Investigation Results in National Settlement With Major Life Insurer, CALIFORNIA DEPARTMENT OF INSURANCE

regularly run its book of in-force life insurance policies and annuities against the DMF to make a determination as to whether the policy holders or annuity holders have died.<sup>147</sup> Additionally, Prudential is then required to make efforts to locate beneficiaries of policy holders in order to pay them policy proceeds.<sup>148</sup> If those policy holders cannot be located, this Regulatory Settlement Agreement requires Prudential to turn over those proceeds to states as required by state unclaimed property laws.<sup>149</sup> The Regulatory Settlement Agreement, entered into by Prudential along with state insurance departments, effectively closes the loop that was begun with the multi-state Global Resolution Agreement (Prudential Agreement) between Prudential and the state treasurers and controllers. The Prudential Agreement, recognizing that the controllers and treasurers have jurisdiction for unclaimed property, sets out requirements for identifying and reporting such property to the states.<sup>150</sup> This is effectively a retrospective agreement, looking backwards through 1992 to identify death benefits that should have been paid and are overdue for escheatment to the states. The Regulatory Settlement Agreement, on the other hand, deals with the insurer's conduct prospectively. Dictating the steps Prudential must take going forward, the Regulatory Settlement Agreement specifies what best practices the insurer must implement in order to avoid repeating past violations.

Also significant is MetLife's announcement in October of 2011 that they will take a charge of \$125 million on their quarterly earnings report to account for life insurance claims that need to be paid.<sup>151</sup> MetLife is quick to point out that this set-aside is a result of the company's recent comprehensive policy sweep and is not a penalty assessed by regulators.<sup>152</sup> Even so, it is clear that regulators are now paying close attention to the

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(Feb. 2, 2012), <http://insurance.ca.gov/0400-news/0100-press-releases/2012/release010-12.cfm> [hereinafter *Regulatory Settlement Agreement*].

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *Id.*

<sup>150</sup> See *Hancock Agreement*, *supra* note 140, at 7-10; see also *Prudential Agreement*, *supra* note 141, at 9-12.

<sup>151</sup> Arthur D. Postal, *MetLife to Take \$125M Unclaimed Property Charge*, LIFEHEALTHPRO (Oct. 7, 2011), <http://www.lifehealthpro.com/2011/10/07/metlife-to-take-125m-unclaimed-property-charge.html>.

<sup>152</sup> *Id.* at 1 (statement of John Calagna, vice president, public affairs, MetLife) (“We did not take a charge for a regulatory investigation. We took a charge for a policy record sweep we began in 2010 before any regulator was investigating the topic.”).

unclaimed property practices of life insurers.<sup>153</sup> In fact, the State of New York, despite neither being a member of the ten-state NAIC task force nor having signed onto the Global Resolution Agreements, is taking strong action of their own. The New York Attorney General's office has issued subpoenas to nine large insurers related to unpaid claims that need to be turned over to the state.<sup>154</sup> Additionally, the New York State Insurance Department has requested information from all 172 life insurers that conduct business in the state.<sup>155</sup>

At the time of this Note's publication, the industry trend towards resolution with state treasurers and controllers, as well as with state insurance regulators, has continued. Subsequent to the Hancock and Prudential Agreements, a number of other major insurers entered into similar Global Resolution Agreements with state controllers and treasurers. Additionally, subsequent to the Regulatory Settlement Agreement entered into by Prudential with the NAIC Task Force, other major insurers entered into similar Regulatory Settlement Agreements with the NAIC Task Force. On April 19, 2012, MetLife entered into both a Global Resolution Agreement with state treasurers and controllers and a Regulatory Settlement Agreement with the NAIC task force.<sup>156</sup> On October 10, 2012, AIG entered into a Global Resolution Agreement and then, on October 19, 2012, also entered into a Regulatory Settlement Agreement.<sup>157</sup> Nationwide

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<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> For the MetLife Global Resolution Agreement, see *Controller Chiang Announces Settlement with MetLife (Global Resolution Agreement)*, CALIFORNIA STATE CONTROLLER'S OFFICE (Apr. 23, 2012), [http://www.sco.ca.gov/eo\\_pressrel\\_9934.html](http://www.sco.ca.gov/eo_pressrel_9934.html); For the MetLife Regulatory Settlement Agreement, see *Florida Announces a \$40 Million Multi-Agency Agreement with MetLife Insurance Companies*, FLORIDA DEPARTMENT OF FINANCIAL SERVICES (Apr. 23, 2012), <http://www.myfloridacfo.com/sitePages/newsroom/allReleases.aspx?year=2012>.

<sup>157</sup> For the AIG Global Resolution Agreement, see *Controller Chiang, Insurance Commissioner Jones Announce Settlement with AIG Insurance (Global Resolution Agreement)*, CALIFORNIA STATE CONTROLLER'S OFFICE (Oct. 22, 2012), [http://www.sco.ca.gov/eo\\_pressrel.html#Apr2012](http://www.sco.ca.gov/eo_pressrel.html#Apr2012); For the AIG Regulatory Settlement Agreement, see *Controller Chiang, Insurance Commissioner Jones Announce Settlement with AIG Insurance*, CALIFORNIA DEPARTMENT OF INSURANCE, (Oct. 22, 2012), <http://www.insurance.ca.gov/0400-news/0100-press-releases/2012/>.

entered into a Global Resolution Agreement on October 9, 2012 and a Regulatory Settlement Agreement on October 11, 2012.<sup>158</sup> Finally, Lincoln Financial entered into a Global Resolution Agreement on December 19, 2012.<sup>159</sup>

Even more recently, on April 1, 2013, a Kentucky trial court ruled, in the case of *United Insurance Corporation of America v. Kentucky*, that a state statute requiring life insurers to search the DMF is a valid exercise of the legislature's powers to regulate the insurance industry.<sup>160</sup> The plaintiff insurers filed a declaratory judgment action challenging the constitutionality of the state statute on the basis of its alleged impairment of the insurers' Contract Clause rights under both the U.S. and Kentucky Constitutions. The court rejected the argument that the statute<sup>161</sup> impaired any vested contractual rights of the insurers while affirming the legitimate purpose of the state in regulating this aspect of insurers' business.<sup>162</sup> The court, using strong language, supported the notion that the industry should undertake proactive steps to locate beneficiaries:

Here, the legislature has sought to remedy the problem of insurance companies holding on to funds that should be paid to beneficiaries upon the death of the insured. The traditional industry practice allows insurance companies to stick their heads in the sand and ignore publicly available

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<sup>158</sup> For the Nationwide Global Resolution Agreement, see *Chiang Announces Settlement with Nationwide (Global Resolution Agreement)*, CALIFORNIA STATE CONTROLLER'S OFFICE (Oct. 11, 2012), [http://www.sco.ca.gov/eo\\_pressrel.html#Apr2012](http://www.sco.ca.gov/eo_pressrel.html#Apr2012); For the Nationwide Regulatory Settlement Agreement, see *Insurance Commissioner Dave Jones Announces Settlement in Death Master Investigation*, CALIFORNIA DEPARTMENT OF INSURANCE, (Oct. 11, 2012), <http://www.insurance.ca.gov/0400-news/0100-press-releases/2012/>.

<sup>159</sup> For the Lincoln Financial Global Resolution Agreement, see CALIFORNIA STATE CONTROLLER'S OFFICE (Dec. 19, 2012), [http://www.sco.ca.gov/serp.html?q=Lincoln+Financial+Global+Resolution+Agreement&cx=001779225245372747843%3Ajzcl\\_x9eh9w&cof=FORID%3A10&ie=UTF-8](http://www.sco.ca.gov/serp.html?q=Lincoln+Financial+Global+Resolution+Agreement&cx=001779225245372747843%3Ajzcl_x9eh9w&cof=FORID%3A10&ie=UTF-8).

<sup>160</sup> Marlys A. Bergstrom et al., *Constitutional Challenge to Kentucky's Death Master File Statute Rejected*, SUTHERLAND, 1 (Apr. 4, 2013), <http://www.sutherland.com/files/upload/ConstitutionalChallengeToKentuckysDeathMasterFileStatuteRejected.pdf>.

<sup>161</sup> The statute at issue was KY. REV. STAT. § 304.15-420.

<sup>162</sup> See Bergstrom et al., *supra* note 160.

data regarding the deaths of their insureds, to the detriment of the beneficiaries (and the public).<sup>163</sup>

## VII. CONCLUSION

Now that Hancock, Prudential, MetLife, AIG, Nationwide and Lincoln Financial have agreed to turn over unclaimed death benefits with interest to the states based on a date of death calculation for dormancy, there has been a seismic shift in the way some of the nation's leading insurers will conduct their business.<sup>164</sup> These companies are not only some of the largest insurers in the country but also, as brand name insurers, they are synonymous with life insurance in the United States. With this in mind, we may see the insurance industry as a whole trending towards this new paradigm. Of course, the far reaching effect of the above mentioned agreements will only be revealed with time, but it is certainly plausible that other insurers follow the example set by these six and agree to escheat unclaimed death benefits to the states using the parameters set forth in these agreements.

The insurance industry should, and likely will, adopt a course of conduct similar to that of Hancock, Prudential, MetLife, AIG, Nationwide and Lincoln Financial. In fact, this Note predicts that, ultimately, the insurance industry will be required (by regulatory enforcement and legislative enactment) to shift from a notice based life insurance payment process to a more proactive approach requiring insurers to determine whether their insureds are deceased irrespective of whether notice has been provided from a beneficiary or family member. There are a number of reasons for insurers to follow this new model. First, the insurance regulators, and to a lesser extent the state controllers and treasurers, have the ability to affect the way insurers do business in this country through regulatory intervention. Second, it is no secret that the regulators look unkindly upon the industry's asymmetrical use of the DMF.<sup>165</sup> The regulators will not be shy in taking steps to prevent this type of conduct, as

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<sup>163</sup> See *id.* at 2.

<sup>164</sup> See *Hancock Agreement*, *supra* note 140, at 11; see also *Prudential Agreement*, *supra* note 141, at 9.

<sup>165</sup> See *supra* Part III Section A for a fuller discussion of the insurance industry's selective use of the DMF; see *supra* Part V for a fuller discussion of the regulators' thoughts on the industry's selective use of the DMF.

well as any other industry conduct which they deem violative of state laws. Finally, state treasurers and controllers, while having no explicit regulatory authority, do have the ability to bring suit to force compliance with their unclaimed property laws.<sup>166</sup> Together, these two entities can exert enormous pressure on the industry to reform their questionable practices and comply with the laws of the various states. Now more than ever, the insurance industry finds itself under the intense glare of the regulatory microscope. Yet, in the midst of regulatory investigations and nationwide audits, there is no better time for the insurance industry to honor the “sacred bargain”<sup>167</sup> it has struck with so many millions of customers. There is no better time for the insurance industry to do the right thing.

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<sup>166</sup> CAL. CIV. PROC. CODE § 1515 (WEST 2007); FLA. STAT. § 717.1331 (2010).

<sup>167</sup> See *California MetLife Hearing*, *supra* note 1, at 11.





# **DOUBLE TROUBLE – AN EX-SPOUSE’S LIFE INSURANCE BENEFICIARY STATUS & STATE AUTOMATIC REVOCATION UPON DIVORCE STATUTES: WHO GETS WHAT?**

KRISTEN P. RAYMOND\*

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*This note analyzes the status of an ex-spouse’s designation as a life insurance beneficiary where the insured has failed to designate a new beneficiary following divorce. The note first discusses life insurance contracts in general, emphasizing that, much like other types of insurance contracts, life insurance contracts are governed by principles of contract law. In fact, it is this basis in contract law which has led most states to uphold the insurance contract and award policy proceeds to the ex-spouse in the event of a dispute over the beneficiary. The note then touches on the minority rule- divorce automatically terminates an ex-spouse’s beneficiary status- before analyzing the constitutionality of automatic revocation statutes within the framework of the Contract Clause. Next, the note discusses the property settlement exception and its application to both the majority and minority rules before concluding with the suggestion that courts employ a two-pronged philosophy in their adjudication of these beneficiary disputes whereby the focus is on executing the insured’s intent and the uniform application of the existing jurisdictional rule.*

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## **I. INTRODUCTION**

Although the marriage rate in the United States has declined in past ten years,<sup>1</sup> the divorce rate has consistently hovered around fifty

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\* J.D./M.B.A. Candidate, University of Connecticut School of Law, 2014; B.A. Bowdoin College, 2008.

<sup>1</sup> *Census: U.S. Marriage Rate at a Record Low*, USA TODAY (Dec. 14, 2011, 5:18 PM), <http://usatoday30.usatoday.com/news/health/wellness/marriage/story/2011-12-14/Census-US-marriage-rate-at-a-record-low/51924344/1>.

percent.<sup>2</sup> Fifty percent of first marriages end in divorce, sixty seven percent of second marriages end in divorce and a staggering seventy four percent of third marriages in the United States fail.<sup>3</sup> While many Americans are aware of rising wedding costs,<sup>4</sup> they don't realize that divorce can cost just as much. The US divorce industry generates about \$28 billion a year, with the average cost of divorce estimated at about \$20,000.<sup>5</sup> Although many couples take into account the high divorce rates before their wedding by signing a prenuptial agreement,<sup>6</sup> few Americans realize that simply saying "I do" may give their soon-to-be ex-spouse a legal right to their life insurance policy's proceeds, regardless of a prenuptial agreement.

Another burgeoning industry in the United States is the life insurance industry. According to Prudential, life insurance is "one of the largest sources of capital in the nation, with \$4.5 trillion invested in the U.S. economy."<sup>7</sup> In total, life insurance premiums alone accounted for 3.8% of U.S. GDP in 2009.<sup>8</sup> Not only does the life insurance industry have a significant impact on the U.S. macro economy, but about "70% of U.S.

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<sup>2</sup> DIVORCE RATE, <http://www.divorcerate.org/> (last visited Feb. 8, 2013).

<sup>3</sup> *Id.* ("50% percent of first marriages, 67% of second and 74% of third marriages end in divorce, according to Jennifer Baker of the Forest Institute of Professional Psychology in Springfield, Missouri.").

<sup>4</sup> The average cost of a wedding in the United States is \$25,631. COST OF WEDDING, <http://www.costofwedding.com/> (last visited Feb. 8, 2013).

<sup>5</sup> Kevin McDonald, *The Cost of a Divorce*, BANKRATE (June 8, 2001), <http://www.bankrate.com/brm/news/advice/19990903a.asp> ("According to maritalstatus.com, a Web site geared toward divorce and remarriage, divorce is a \$28 billion-a-year industry with an average cost of about \$20,000.").

<sup>6</sup> Claudia Buck, *More and More Couples Use Prenuptial Agreements*, ABC2NEWS, (Apr.18, 2011), [http://www.abc2news.com/dpp/money/personal\\_finance/more-and-more-couples-use-prenuptial-agreements-wptv1303137646047#ixzz1eFgiHyN2](http://www.abc2news.com/dpp/money/personal_finance/more-and-more-couples-use-prenuptial-agreements-wptv1303137646047#ixzz1eFgiHyN2) ("In a survey of American Academy of Matrimonial Lawyers released last September, 73 percent said they have seen an increase in 'prenups' during the past five years.").

<sup>7</sup> *The Importance of Life Insurance Industry in the U.S.*, PRUDENTIAL LIFE INS., [http://research.prudential.com/media/managed/documents/research\\_perspective/Importance\\_of\\_Life\\_Insurance\\_Industry.pdf](http://research.prudential.com/media/managed/documents/research_perspective/Importance_of_Life_Insurance_Industry.pdf) (last visited Feb. 8, 2013) (citing AM. COUNCIL OF LIFE INS., *Life Insurers Protecting Families, Building America*, available at [http://www.acli.com/Tools/Industry%20Facts/Documents/Protecting\\_Families.pdf](http://www.acli.com/Tools/Industry%20Facts/Documents/Protecting_Families.pdf)).

<sup>8</sup> *Id.* (citing LIMRA, ANALYSIS OF BUREAU OF ECONOMIC ANALYSIS AND SNL FINANCIAL LLC DATA (2010)).

households depend on life insurance industry products to protect their financial and retirement security.”<sup>9</sup> Americans rely on the \$59 billion in yearly death benefits paid out by life insurance companies to provide for their families in the event of their death.<sup>10</sup>

As unpleasant as dealing with the possibility of divorce may be when drafting a prenuptial agreement, addressing what becomes of life insurance proceeds in the event a deceased spouse forgets to change the beneficiary status of his life insurance policy after a divorce is a tougher issue to tackle. Because a life insurance policy constitutes a separate contract between the insured policyholder and the insurance company, life insurance is a nonprobate asset that does not get settled through the probate system when the insured dies. The high divorce rates in the United States, in conjunction with the growing use of life insurance policies for financial protection for family and inheritance money,<sup>11</sup> create a growing number of issues when insureds do not change the beneficiary status of an ex-spouse after a divorce. Conflict arises between the insured’s intent to change his ex-spouse’s beneficiary status and the insurance company’s duty to uphold the letter of the life insurance contract by paying the contract proceeds to the insured’s designated beneficiary.

Many divorcing Americans struggle when dividing assets, spending vast amounts of time and money on attorneys to strike an equal balance. This note explores the effect of divorce on a beneficiary spouse’s right to life insurance proceeds, focusing on the impact of state enacted

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<sup>9</sup> While 70% of Americans rely on insurance policies and products to protect their financial and retirement security, a little under half of U.S. households own individual life insurance policies. *Id.* (citing Eric Soundergeld, LIMRA, THE FACTS OF LIFE AND ANNUITIES (Sept. 2010)).

<sup>10</sup> *Id.* (citing AM. COUNCIL OF LIFE INS., *Life Insurers Protecting Families, Building America*, available at [http://www.acli.com/Tools/Industry%20Facts/Documents/Protecting\\_Families.pdf](http://www.acli.com/Tools/Industry%20Facts/Documents/Protecting_Families.pdf)) (“Over \$59 billion in death benefits and \$67 billion in annuity benefits paid in 2009.”).

<sup>11</sup> The main reasons to purchase life insurance are to: replace income for dependents, pay final expenses, create an inheritance for heirs, pay federal and state “death” taxes, make significant charitable contributions, and create a source of savings. *Life Insurance Basics*, INSURANCE INFORMATION INSTITUTE, <http://www2.iii.org/insurance-handbook/insurance-basics/life-insurance-basics.html> (last visited Mar. 1, 2013); *Results of Poll of Reasons People Purchase Life Insurance Announced*, YAHOO! NEWS, <http://news.yahoo.com/results-poll-reasons-people-purchase-life-insurance-announced-210221574.html> (Nov. 16, 2011).

automatic revocation statutes. Typically, divorce alone does not affect the designated soon to be ex-spouse's right to proceeds. Absent a change in beneficiary designation, many courts will award a policy's proceeds to the former spouse over the claim of a current spouse, or other purported beneficiary.<sup>12</sup> However, some states have enacted legislation to automatically revoke a spouse as beneficiary to a life insurance policy that is owned by the other spouse upon divorce.<sup>13</sup> Whether courts have protected an ex-spouse's status as a life insurance beneficiary, issues arise when the divorce agreement did not discuss the policy, and additional issues arise in states that have enacted legislation to automatically revoke a now ex-spouse's status as a beneficiary, but the policyholder purchased his policy before the legislation was enacted.

Some states have statutory provisions that attempt to provide that a divorce revokes the former spouse's beneficiary status except as otherwise specified by court order.<sup>14</sup> Some courts have found these statutes unconstitutional because the beneficiary's status stems from the insurance *contract*, and the legislature cannot abrogate this part of the insurance contract upon divorce.<sup>15</sup> Even when the relevant state has such a statute, it may not apply if the plan has contrary provisions, such as a provision that a divorce or anything other than the plan's beneficiary designation form has no effect upon the beneficiary designation.

This note examines the policies behind whether or not to adopt an automatic revocation statute for life insurance beneficiary designations upon divorce, and recent developments by state supreme courts or legislatures discussing the adoption of automatic revocation statutes or the property settlement agreement exception. Additionally, this note touches upon recent court rulings on the constitutionality of such laws, specifically in the context of the Contract Clause.<sup>16</sup> I argue that all jurisdictions, in keeping with the goal of upholding the insured's intent in forming the insurance contract, should adopt the property settlement agreement exception as a means to opt-out of the existing jurisdictional rule.

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<sup>12</sup> See *infra* Part III; see, e.g., *Life Ins. Co. of N. Am. v. Ortiz*, 535 F.3d 990 (9th Cir. 2008).

<sup>13</sup> See *infra* Part IV; see, e.g., *Lincoln Benefit Life Co. v. Heitz*, 468 F. Supp. 2d 1062 (D. Minn. 2007).

<sup>14</sup> See *infra* Part VI.

<sup>15</sup> See *infra* Part V.

<sup>16</sup> U.S. CONST. art. I, § 10, cl. 1 ("No State shall . . . pass any . . . Law impairing the Obligation of Contracts . . .").

Additionally, courts and legislatures should aim to uniformly apply the existing jurisdictional rule in conjunction with the property settlement agreement opt-out in order to reduce both the number of legal challenges and the amount of time for intended beneficiaries to receive this nonprobate transfer of wealth.

This note does not address federal preemption issues that have arisen with pension plans and life insurance in the context of the *Employee Retirement Income Security Act* of 1974 [hereinafter ERISA].<sup>17</sup> Rather, this note focuses solely on privately purchased life insurance policies.

Part II of this note discusses the nature of the life insurance contract. Part III explains the policy reasons behind the traditional majority rule while Part IV addresses the modern trend of automatic revocation statutes, currently considered the minority rule in this area of law. Parts V and VI describe the recent Contracts Clause issue in jurisdictions that have passed automatic revocation statutes and the arguments for and against the constitutionality of these pieces of legislation. Part VII explains the recent property settlement agreement exception that proposes a way to opt-out of existing jurisdictional rules. In part VIII, I submit what courts or legislatures can do to provide clarity in this area of law in light of the purpose of life insurance and goal of executing the insured's intent.

## II. THE LIFE INSURANCE CONTRACT

In a life insurance policy, the insured “enters[s] into a contract with an insurance company that promises to provide [the insured’s] beneficiaries with a certain amount of money upon [the insured’s] death. In return, [the insured] make[s] periodic payments, called *premiums*. The premium amount is based on factors such as [the insured’s] age, gender, medical history, and the dollar amount of life insurance . . . purchase[d]. In the event of [the insured’s] passing, life insurance provides money directly

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<sup>17</sup> The Employee Retirement Income Security Act of 1974 regulates employee pension benefit plans. 29 U.S.C. § 1002(2)(A) (2006) (originally enacted as Pub. L. No. 93-406, 88 Stat. 829). The Supreme Court recently addressed the issue of whether ERISA’s qualified domestic relations order is the only valid way a divorcing spouse can waive her right to receive her ex-spouse’s pension benefits under ERISA. *Kennedy v. Plan Adm’r for DuPont Sav. And Inv. Plan*, 555 U.S. 285 (2009).

to [his] beneficiaries.”<sup>18</sup> Unlike other assets that transfer at the time of death, typically through the lengthy probate process, life insurance is “usually transferred directly to the named beneficiaries.”<sup>19</sup>

Life insurance policies, along with the majority of insurance contracts, are governed by the principles of contract law.<sup>20</sup> In order to acquire a life insurance policy, one must have an “insurable interest”<sup>21</sup> in the life of the insured.<sup>22</sup> Because each person holds an insurable interest in his own life, the insured who takes out a life insurance policy on his own life is generally free to designate the beneficiary of his choosing.<sup>23</sup> In the past, insurance companies had limited an individual’s ability to take out a life insurance policy on his spouse’s life. Insurance companies required individuals to establish an insurable interest by demonstrating an economic dependence on the spouse in order to successfully issue a life insurance policy.<sup>24</sup> The modern rule<sup>25</sup>, established from a combination of case law and state statutes, holds that “husbands and wives can insure each other’s

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<sup>18</sup> *Life Insurance: An Introduction*, METLIFE, <http://www.metlife.com/individual/life-advice/personal-insurance/life-insurance-policies/index.html> (last visited Feb. 19, 2013) (alteration in original).

<sup>19</sup> Sandra Block, *Divorce Doesn’t Mean Your Ex is No Longer Your Beneficiary*, USA TODAY (Sept. 7, 2004, 9:40 PM), [http://usatoday30.usatoday.com/money/perfi/columnist/block/2004-09-06-block\\_x.htm](http://usatoday30.usatoday.com/money/perfi/columnist/block/2004-09-06-block_x.htm) (“By the time most estates cleared probate, the beneficiaries may already have received the money . . .”).

<sup>20</sup> See also 16 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS § 49:14 (4th ed. 1993).

<sup>21</sup> *Insurable Interest*, INSURANCE INFORMATION INSTITUTE, <http://www2.iii.org/index.cfm?instanceID=268> (last visited Feb. 19, 2013) (“[A] person exhibits an insurable interest in a potential loss if that person will suffer a genuine economic loss if the event insured against occurs. Without the presence of insurable interest, an insurance contract is not formed for a lawful purpose and, thus, is not a valid contract.”).

<sup>22</sup> BERTRAM HARNETT & IRVING I. LESNICK, THE LAW OF LIFE AND HEALTH INSURANCE §2.04[1] (Matthew Bender, Rev. Ed. 2011) [hereinafter LIFE AND HEALTH INSURANCE].

<sup>23</sup> *Id.* (noting that the majority of states currently hold that a beneficiary does not need to have an insurable interest on the insured’s life); see also Block, *supra* note 19 (noting that many Americans have various accounts and policies with beneficiaries, ranging from individual or employer-provided retirement accounts to variable annuities and insurance policies).

<sup>24</sup> LIFE AND HEALTH INSURANCE, *supra* note 22 at §2.04[1][a].

<sup>25</sup> See *infra* Part IV.

lives, regardless of their actual economic relationship.”<sup>26</sup> A looser rule as to who has the requisite insurable interest to acquire life insurance applies in most other states. These states loosely define insurance interest as “in the case of persons closely related by blood or by law, a substantial interest engendered by love and affection.”<sup>27</sup>

Once the insured designates a beneficiary of his life insurance policy, the rights of the beneficiary “can only be terminated by an affirmative act to modify or terminate the insurance contract in some way or by creating a separate agreement which overrides the beneficiary designation in the life insurance contract.”<sup>28</sup> When the insured dies, the terms of the insurance contract dictate that the insurance company will pay the policy’s proceeds to the insured’s designated beneficiary.<sup>29</sup>

An ex-spouse named as a beneficiary to the insured’s life insurance contract would not meet the traditional test for having an insurable interest. However, the “insurable interest requirement, if applicable at all, applies as of the time the life insurance coverage is *initiated*.”<sup>30</sup> Therefore, a divorce that occurred long after the insured designated his then-spouse as beneficiary to his life insurance policy has no effect on the insurable interest.<sup>31</sup> The beneficiary’s claim to insurance proceeds does not stem from her spousal status but rather stems from the terms of the insurance policy issued when she had an insurable interest on her ex-spouse.<sup>32</sup>

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<sup>26</sup> LIFE AND HEALTH INSURANCE, *supra* note 22, at §2.05[1][b] (alteration in original) (“Missouri and Arkansas have explicit statutes specific statutes reciting the insurable interest a wife has in her husband, while Ohio . . . recogniz[es] the insurable interest one spouse has in the other spouse’s life.”); *see* ARK. CODE ANN. § 23-79-108; OHIO REV. CODE ANN. § 3911.11 (West 1986); MO. REV. STAT. § 376.530 (1985), *repealed by* L.2007, S.B. No. 613 Revision, § A.

<sup>27</sup> LIFE AND HEALTH INSURANCE, *supra* note 22 at §2.05[1][b] (internal quotation marks omitted).

<sup>28</sup> Domenico Zaino, Jr., *The Practical Effect of Extending Revocation By Divorce Statutes to Life Insurance*, 2 CONN. INS. L.J. 213, 217 (1996) (citing 44 AM. JUR. 2D, *Insurance*, §§ 1714, 1750-51 (1982 & Supp. 1995)).

<sup>29</sup> *See* HARRY P. KAMEN & WILLIAM J. TOPPETA, *THE LIFE INSURANCE LAW OF NEW YORK* 215 (1989).

<sup>30</sup> LIFE AND HEALTH INSURANCE, *supra* note 22 at §2.05[1][e][i] (emphasis added).

<sup>31</sup> *See also Id.*

<sup>32</sup> *See* 29-180 ERIC MILLS HOLMES & MARK S. RHODES, *APPLEMAN ON INSURANCE* § 180.11[A][1] (2d ed. 1996) [hereinafter *APPLEMAN ON INSURANCE*].



Given that courts must enforce the terms of a private life insurance policy, including beneficiary designation,<sup>33</sup> issues of the insured's intent to disburse funds to the designated beneficiary typically arise when the insured either forgets to affirmatively change his ex-spouse as the beneficiary of his life insurance policy after a divorce or neglects to clearly address, or address at all, an existing life insurance policy in a property settlement agreement or divorce decree.

Although the simplest opportunity to prevent this issue from occurring exists during divorce proceedings, by informing the insured of the nature of state case law regarding an ex-spouse's beneficiary status, the issue is commonly overlooked.<sup>34</sup> Since life insurance benefits are paid after the insured policyholder has died and can no longer state who he desires as his intended beneficiary, thus causing this issue, it remains more important for clear case law to exist regarding this matter when proactive legal counseling cannot help.

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<sup>33</sup> See *Ping v. Denton*, 562 S.W.2d 314, 316 (Ky. 1978) ("A policy of insurance is nothing more nor less than a contract wherein an insurance company, for valuable consideration, agrees to pay a sum of money on a specified contingency to a designated person called a beneficiary."); *Shaffer v. Winhealth Partners*, 261 P.3d 708, 711 (Wyo. 2011) ("An insurance policy constitutes a contract between insurer and insureds."); APPLEMAN ON INSURANCE, *supra* note 32, at §180.11(A)(1).

<sup>34</sup> But see Lauren J. Wolven and Ashley Crettol, *Life Insurance Litigation Post-Divorce: Easy to Avoid, Commonly Neglected*, HORWOOD MARCUS & BERK (Aug. 2, 2010), [http://hmbllaw.com/publications/life-insurance-](http://hmbllaw.com/publications/life-insurance-litigation-post-divorce-easy-to-avoid-commonly-neglected.aspx)

[litigation-post-divorce-easy-to-avoid-commonly-neglected.aspx](http://hmbllaw.com/publications/life-insurance-litigation-post-divorce-easy-to-avoid-commonly-neglected.aspx) ("[O]ne essential step in addressing the issue is to include specific language in a prenuptial agreement or in the divorce decree indicating that any beneficiary designations (excluding ERISA) will be deemed revoked with respect to that spouse. Such provisions should also include a requirement that the spouses cooperate with any subsequent paperwork necessary to perfect the waiver. Ideally, the provision should also reference the specific policy numbers, so as to avoid any claims that the waiver is broadly worded."). This approach works in most, but not all states, as the majority of states have adopted the property settlement agreement exception providing that specific language clearly delineating the insured's intended beneficiary in either the prenuptial agreement or divorce decree adequately delineates the insured's intended policy beneficiary.

### III. MAJORITY RULE: DIVORCE DOES NOT AFFECT AN EX-SPOUSE'S BENEFICIARY STATUS

States applying the majority rule, which upholds the terms of the insurance contract, do not change the ex-spouse's beneficiary status even after divorce, if the ex-spouse is still listed as the beneficiary.<sup>35</sup> These states hold that divorce per se does not affect a designated ex-spouse's right to receive life insurance proceeds. Here, proceeds from life insurance policies "are deemed payable to the named beneficiary as a matter of law irrespective of a subsequent divorce between the insured and the beneficiary."<sup>36</sup>

These courts hold that unless the terms of the insurance policy specifically dictate that the spouse's beneficiary status is conditioned on the continuation of the marriage, divorce does not per se affect or defeat any of the vested rights of the ex-spouse as designated beneficiary.<sup>37</sup> Some states that apply the majority rule allow for the property settlement agreement exception, but only allow the exception to the extent that the

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<sup>35</sup> Jurisdictions that follow this rule include: Arkansas, District of Columbia, Alabama, Illinois, Indiana, Iowa, Kansas, Massachusetts, Montana, New Hampshire, New Mexico, North Carolina, South Carolina, and Wisconsin. *See, e.g.,* MFA Life Ins. Co. v. Kyle, 630 F.2d 322, 323 (6th Cir. 1980) (applying Arkansas law); Estate of Bowden v. Aldridge, 595 A.2d 396, 397-98 (D.C. 1991); Rountree v. Frazee, 209 So. 2d 424, 426 (Ala. 1968); Allen v. Allen, 589 N.E.2d 1133, 1137 (Ill. App. Ct. 1992); Hancock v. Ky. Cent. Life Ins. Co., 527 N.E.2d 720, 723 (Ind. Ct. App. 1988); Sorensen v. Nelson, 342 N.W.2d 477, 479 (Iowa 1984); Cincinnati Life Ins. Co. v. Palmer, 94 P.3d 729, 733 (Kan. Ct. App. 2004); Stiles v. Stiles, 487 N.E.2d 874, 875 (Mass. App. Ct. 1986); Eschler v. Eschler, 849 P.2d 196, 201 (Mont. 1993); Dubois v. Smith, 599 A.2d 493, 497 (N.H. 1991); Harris v. Harris, 493 P.2d 407, 409 (N.M. 1972); Daughtry v. McLamb, 512 S.E.2d 91, 92 (N.C. Ct. App. 1999); Estate of Revis v. Revis, 484 S.E.2d 112, 116 (S.C. Ct. App. 1997); Bersch v. Van Kleeck, 334 N.W.2d 114, 116 (Wis. 1983).

<sup>36</sup> Zaino, *supra* note 28 at 217; *see also* HARRY P. KAMEN & WILLIAM J. TOPPETA, THE LIFE INSURANCE LAW OF NEW YORK 215 (1989) ("By contract, policy proceeds are payable to the named beneficiaries, and several beneficiaries may be designated for specified shares.").

<sup>37</sup> *See Cincinnati Life Ins. Co.*, 94 P.3d at 733; *see also* Hollaway v. Selvidge, 548 P.2d 835, 838 (Kan. 1976); *Stiles*, 487 N.E.2d at 875 n. 3; *Bersch*, 334 N.W.2d at 116.

court order clearly addresses the beneficiary status designation.<sup>38</sup> If this exception does not apply in states that adopted the majority rule that allow for the property settlement agreement exception, the designated beneficiary remains the beneficiary even though he is now an ex-spouse.

In an often-cited Kentucky case supporting the majority rule, *Ping v. Denton*, the court summarized the rationale behind the application of the majority rule in light of the state's revocation of a statute providing for automatic termination of an ex-spouse's designation as a life insurance beneficiary upon divorce.<sup>39</sup> In *Ping v. Denton*, the administratrix of the insured's estate brought an action against the insured's former wife to recover the life insurance proceeds that the insurance company had previously paid to the ex-spouse, who had remained the beneficiary of the policy after the couple legally dissolved their marriage.<sup>40</sup> As Kentucky had repealed its automatic revocation statute, the divorce did not necessarily terminate the ex-wife's interest as a beneficiary of the policy.<sup>41</sup> Instead, the insured:

[A]lone determined to make [his ex-spouse] the beneficiary at a time [before] they were married. This he had a right to do. [The insured] alone determined to retain [his ex-spouse] as the beneficiary during the period of their marriage. This he had a right to do. [The insured] alone determined not to take from [his ex-spouse] the interest of a beneficiary. This he had a right to do. [The insured] alone owned and controlled the policy and the right to change the beneficiary if he chose to do so. Not having changed the beneficiary at the time of his death, [his ex-spouse] was entitled to receive the proceeds from the policy of insurance.<sup>42</sup>

Here, the court was wary of re-interpreting the deceased's intent in not changing his life insurance beneficiary after his divorce, placing

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<sup>38</sup> See, e.g., *Cincinnati Life Ins.*, 94 P.3d at 733. For a discussion of the property settlement exception, see *infra* Part VII.

<sup>39</sup> *Ping*, 562 S.W.2d at 316.

<sup>40</sup> *Id.* at 314.

<sup>41</sup> *Id.* at 317.

<sup>42</sup> *Id.* (alteration in original) (citations omitted).

priority on executing the insured's formal intent evidenced by the text of his life insurance policy.<sup>43</sup>

Courts and legislatures that have adopted the majority rule in honoring the insurance contract have given three main reasons for doing so. Courts and legislatures adopting the majority rule are fearful about the potential for the court guessing about the insured's intent when interpreting the insurance contract.<sup>44</sup> Because the problem with deciphering whether or not the insured intended to leave an ex-spouse as a beneficiary of a life insurance policy always arises after the insured died, courts cannot simply ask the insured to make his intent clear. The courts must consider whether the insured's failure to make a formal beneficiary change when the beneficiary has relinquished or been divested of the right to continue in such status still then indicates that the insured intends his ex-spouse to receive the proceeds anyways. In order to minimize the amount of guesswork done by courts in sorting out this issue, jurisdictions adopting the majority rule note that an insured's failure to formally change his ex-spouse's status as life insurance beneficiary after their divorce is evidence in and of itself of the insured's intent for his ex-spouse to remain the policy's beneficiary, despite the absence of any legal requirement in connection with their divorce.<sup>45</sup> Simply put, the insured could have changed the policy's beneficiary had he wished to do so, so the courts should not actively interfere with an insurance contract, especially when the insured is no longer able to make his intent clear. Courts and legislatures that have adopted the majority rule also note that the insured who wished to have his ex-spouse retain her beneficiary status should not needlessly have to go through the exercise of re-designating his ex-spouse as the beneficiary with an automatic revocation statute.<sup>46</sup> These courts hold that simply retaining an ex-spouse as the legal beneficiary of the policy establishes clear evidence of the insured's intent.

A second reason courts adopt the majority rule is to preclude the insurer from being held liable for dispensing the policy's proceeds, which, as a non-probate asset, are quickly disbursed after the policyholder's death,

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<sup>43</sup> *See id.*

<sup>44</sup> *See* LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][A].

<sup>45</sup> *See id.* Some divorce decrees include provisions requiring an ex-spouse to maintain life insurance as a part of child support or alimony. *Divorce*, AXA EQUITABLE, <http://www.axa-equitable.com/plan/divorce/overview.html> (last visited Jan. 8, 2012).

<sup>46</sup> *See* APPLEMAN ON INSURANCE, *supra* note 32, at §180.11(A)(1).

to the wrong beneficiary.<sup>47</sup> When issues of the insured's intent in change of beneficiary arise, the insurance company can be sued from either the primary or contingent beneficiary for incorrectly dispensing the funds.<sup>48</sup>

Most recently, majority rule jurisdiction Kansas amended its statute that provided that a divorce decree must provide for changes in beneficiary designation.<sup>49</sup> In *Cincinnati Life Ins. Co. v. Palmer*, a life insurer filed an interpleader action to resolve competing claims by the insured's ex-spouse, the primary beneficiary and mother, the contingent beneficiary.<sup>50</sup> In considering the statutory amendment Kan. Stat. Ann. §60-1610(b), which is presently codified at §23-2802, the court addressed whether the statute imposed a requirement that a "beneficiary change be filed with the insurer in order to make an express provision in a divorce decree effective, or whether this provision is intended for the protection of the insurer that might be unaware of the decree."<sup>51</sup> The court held that the divorce decree did not affect the designation of a non-spouse as the new beneficiary of the policy because the decree didn't contain an express change of beneficiary provision, which the court ruled was necessary under the statute for a decree to effect the designation.<sup>52</sup>

The third policy reason for upholding the insurance contract derives from life insurance categorization as a non-probate asset, so courts should not play an active role in its disbursement, and considering that life insurance is a contract between two private parties, courts are bound to

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<sup>47</sup> In times where the insurance company swiftly anticipates a lawsuit from a non-designated beneficiary, the insurance company must interplead all parties involved to preclude its own liability for the wrongful disbursement of insurance proceeds. *See, e.g., Cincinnati Life Ins. Co. v. Palmer*, 94 P.3d 729 (Ky. Ct. App. 2004).

<sup>48</sup> *See id.* at 731.

<sup>49</sup> KAN. STAT. ANN. § 23-2802(d) (2011) (previously codified as 60-1610(b) ("nothing in this section shall relieve the parties of the obligation to effectuate any change in beneficiary designation by the filing of such change with the insurer or issuer in accordance with the terms of the policy."); *see also* LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][A].

<sup>50</sup> *Cincinnati Life Ins.*, 94 P.3d at 729.

<sup>51</sup> LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][A]; *see also Cincinnati Life Ins.*, 94 P.3d at 729.

<sup>52</sup> *Cincinnati Life Ins.*, 94 P.3d at 733.

follow the policy terms and apply contract law principles when disputes arise.<sup>53</sup>

The majority rule is not without its flaws. It does not take into account the intricacies of ex-spousal personal relations in deciding what the insured's intent was. Instead, the courts seem more concerned to minimize potential insurer liability by executing the formal beneficiary designation from the life insurance policy to allow for the quick disbursement of the policy's proceeds without such an event causing the insurer to be open to litigation.

#### IV. MINORITY RULE – DIVORCE AUTOMATICALLY REVOKES EX-SPOUSE'S BENEFICIARY STATUS

Other states have adopted, either through legislation or judicial mandate, the minority rule, whereby a final divorce automatically revokes the status of the designated spouse as a beneficiary and terminates their right to the life insurance proceeds of their former spouse.<sup>54</sup> States that have adopted the minority rule include Michigan, Colorado, Minnesota, Missouri, Ohio, Arizona, Oklahoma, and Texas.<sup>55</sup> Many, but not all, of these states have based their revocation statute on the 1990 revisions of the Uniform Probate Code [hereinafter "UPC"] that reflect "the rapidly increasing use of will substitutes, the evolution of domestic relationships,

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<sup>53</sup> See KAMEN & TOPPETA, *supra* note 29. The ex-spouse's claim is not derived from status of the relationship, but rather from the terms of the policy. APPLEMAN ON INSURANCE, *supra* note 32, at §180.11(A)(1).

<sup>54</sup> See *Lincoln Benefit Life Co. v. Heitz*, 468 F. Supp. 2d 1062, 1066 (D. Minn. 2007); NEW APPLEMAN INS. LAW PRACTICE GUIDE §34.31 (Jeffrey E. Thomas et al. eds. 2013).

<sup>55</sup> See, e.g., ARIZ. REV. STAT. ANN. § 14-2804 (1956); MINN. STAT. § 524.2-804 (2012); MO. REV. STAT. § 461.051.2 (2007); OHIO REV. CODE ANN. § 5815.33 (2012) (previously codified as § 1339.63); OKLA. STAT. tit. 15, § 178 (1993); TEX. FAM. CODE ANN. § 9.301(a) (2006) (previously codified as § 3.632(b)); WASH. REV. CODE 11-07-010 (2012).

and the decline of formalism in private law.”<sup>56</sup> Specifically, the statutes are based on section 2-804 of the 1990 UPC.<sup>57</sup>

The Michigan legislature adopted a revocation statute<sup>58</sup> in 1939 that terminated the designated spouse’s “right to proceeds or interest in the policy upon divorce, unless the decree provides otherwise or unless the insured spouse takes some action to see that the ex-spouse is again designated.”<sup>59</sup> Michigan courts have utilized the statute to “foreclose a designated wife’s interest where she claimed to have interest in two life insurance policies on her ex-husband’s life by reason of a contractual arrangement with him.”<sup>60</sup> Because “the divorce decree did not mention the policies . . . the court held that the statute terminated her rights in them.”<sup>61</sup>

In Colorado, the legislature superseded existing case law supporting the majority rule that divorce did not abrogate an ex-spouse’s beneficiary status by enacting essentially a divorce revocation statute.<sup>62</sup> The Colorado legislature adopted language almost identical to the UPC 2-804 in its divorce revocation statute. The legislation allows for an exception to the automatic revocation of an ex-spouse’s beneficiary status if the insured inserts an express provision allowing for the ex-spouse to retain her beneficiary status in a property settlement agreement.<sup>63</sup> Unlike states adopting the majority rule, the Colorado legislature believed the insured more likely did not intend to have an ex-spouse remain a beneficiary and that his failure to make a formal change to the policy’s beneficiary merely constituted an oversight.<sup>64</sup>

Minnesota’s divorce revocation statute provides that that dissolution of marriage revokes any designation as beneficiary of a spouse

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<sup>56</sup> Suzanne Soliman, *A Fair Presumption: Why Florida Needs a Divorce Revocation Statute for Beneficiary-Designated Nonprobate Assets*, 36 STETSON L. REV. 397, 402 (2007); see, e.g., ARIZ. REV. STAT. ANN. § 14-2804 (1956); COLO. REV. STAT. § 15-11-804 (2012); UTAH CODE ANN. § 75-2-804 (1998); WASH. REV. CODE § 11.07.010 (2012); WISC. STAT. ANN. § 854.15(3)(a) (2002).

<sup>57</sup> UNIF. PROB. CODE § 2-804 (amended 2010).

<sup>58</sup> MICH. COMP. LAWS § 552.101 (2007).

<sup>59</sup> LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][C].

<sup>60</sup> *Id.* (citing *Northeastern Life Ins. Co. of N.Y. v. Cisneros*, 392 F.2d 198 (6th Cir. 1968) (applying Michigan law)).

<sup>61</sup> *Id.*

<sup>62</sup> COLO. REV. STAT. § 15-11-804(2)(a) (2012) (overruling *Christensen v. Sabad*, 773 P.2d 538 (Colo. 1989)).

<sup>63</sup> COLO. REV. STAT. § 15-11-804(2)(a).

<sup>64</sup> See Soliman, *supra* note 57, at 403-04.

in a life insurance policy, except as otherwise provided by a “governing instrument, . . . a court order, a contract relating to the division of the martial property . . . , or a plan document governing a qualified or nonqualified retirement plan.”<sup>65</sup> The statute permits the insured to change his beneficiary upon the dissolution of marriage, as long as the change remains in line with any conditions imposed by the divorce proceedings and provisions (such as a property settlement agreement) per Minn. Stat. Ann. § 61A.12(4). In Minnesota, like in many other states that have enacted such divorce revocation statutes, people have brought suits arguing the statute violated the Contract Clause.<sup>66</sup> In 2007, a federal district court held that the Minnesota statute, if applied to revoke a beneficiary designation that preexisted its effective date, was not an impairment of contract so as to violate the United States Constitution.<sup>67</sup> Alternatively, in 2008 another federal district court in Minnesota held that the retroactive application of Minnesota’s automatic revocation statute as applied violated the Contract Clause.<sup>68</sup>

Under Missouri law, the dissolution of marriage after a life insurance policy owner’s designation of the spouse or of a relative of the spouse as the beneficiary revokes the beneficiary’s designation.<sup>69</sup> In 2001, however, Missouri enacted legislation providing that the divorce revocation statute does not apply “to transfers pursuant to life or accidental death products sold by insurance companies unless the statute is

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<sup>65</sup> MINN. STAT. § 524.2-804 (2012).

<sup>66</sup> See *infra* Parts V-VI.

<sup>67</sup> *Lincoln Ben. Life Co. v. Heitz*, 468 F. Supp. 2d 1062, 1067 (D. Minn. 2007) (holding no Contract Clause issue existed because an ex-spouse’s beneficiary designation prior to divorce did not create a vested contractual right in the ex-spouse sufficient to allege a Contract Clause challenge).

<sup>68</sup> *MONY Life Insurance Co. v. Ericson*, 533 F. Supp. 2d 921, 923-24 (D. Minn. 2008) (noting the Contract Clause issue exhibits the heightened level of uncertainty in this area of law. In addition to the jurisdictional split in between majority and minority rule, a split of authority exists in minority jurisdictions that have retroactively applied divorce revocation statutes).

<sup>69</sup> MO. ANN. STAT. § 461.051.1 (1989); see, e.g., *Gillespie v. Estate of McPherson*, 159 S.W.3d 466, 471 (Mo. Ct. App. 2005) (holding that divorce revoked the designation of an insured’s second wife as beneficiary of life insurance policy and no existing exceptions to the revocation statute applied, so second wife was not entitled to policy’s proceeds).



incorporated into the policy or beneficiary designation.”<sup>70</sup> However unlike in Minnesota where the federal district court rejected a Contract Clause challenge to a retroactively applied provision affecting an insurance contract, this legislation amending the original divorce revocation statute could not be applied retroactively.<sup>71</sup> The court explained that Mo. Rev. Stat. §461.051’s automatic revocation on dissolution provision, governing the effect that a dissolution of marriage had on nonprobate transfers to former spouses, did not apply to the decedent’s and former wife’s divorce, because at the time of the dissolution, Mo. Rev. Stat. §461.073, which controlled the scope and application of the nonprobate transfers law, stated that §461.051 “did not apply to property, money, or benefits paid or transferred at death pursuant to a life or accidental death insurance policy, annuity, contract, plan, or other product sold or administered by a life insurance company.”<sup>72</sup> Therefore, the court held that the decedent’s designation of his former wife as the beneficiary of his life insurance policy was valid at the time of his death.<sup>73</sup>

The Ohio legislature invoked its divorce revocation statute in 1990. The legislative text revokes an ex-spouse’s beneficiary status upon divorce. However, unlike other legislative enactments based on UPC section 2-804, the Ohio statute is located in Ohio’s Revenue Code and specifically mentions life insurance designations. Ohio’s divorce revocation statute is located in its commercial code and contains language specific to nonprobate assets such as life insurance.<sup>74</sup> This Ohio Revenue Code provision provides that divorce automatically revokes the ex-spouse’s beneficiary status for policies owned by the insured spouse,<sup>75</sup> unless a divorce decree or judgment granting the divorce specifically

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<sup>70</sup> LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][C] (citing MO. REV. STAT. § 461.073.6 (1995) (as amended by 2001 H.B. 644 and 2001 S.B. 227)). Exceptions included irrevocable beneficiary designations, designations made after the dissolution, designations that expressly stated that it shall not be affected by a future dissolution. MO. REV. STAT. § 461.051.2.

<sup>71</sup> *United Investors Life v. Wilson*, 191 S.W.3d 76, 77 (Mo. Ct. App. 2006).

<sup>72</sup> *Id.* at 78 (citing MO. REV. STAT. § 461.051).

<sup>73</sup> *Id.* at 79.

<sup>74</sup> OHIO REV. CODE ANN. § 1339.63 (West 1990).

<sup>75</sup> For the purpose of the insurance contract, “[ex-]spouse shall be deemed to have predeceased the spouse who made the designation or on whose behalf the designation was made. *Id.* (alteration in original).

provides otherwise.<sup>76</sup> Also included in Ohio's divorce revocation statute is a provision addressing the insurer liability issue which provides:

[a]n agent, bank, broker, custodian, issuer, life insurance company, plan administrator, savings and loan association, transfer agent, trustee, or other person is not liable in damages or otherwise in a civil or criminal action or proceeding for distributing or disposing of property in reliance on and in accordance with a designation of beneficiary.<sup>77</sup>

A 1987 Oklahoma statute revokes an ex-spouse's beneficiary status unless the insured goes through the process of formally re-naming the ex-spouse as the intended beneficiary following their divorce.<sup>78</sup> Oklahoma's statute has been deemed unconstitutional if applied to contracts retroactively because it violated the Contract Clause.<sup>79</sup> To remedy constitutional issues with its divorce revocation statute while still adopting the minority rule, the Oklahoma legislature since amended its statute to render it applicable only to insurance contracts entered on or after the statute's effective date.<sup>80</sup>

Texas's 1987 divorce revocation statute is not modeled on UPC section 2-804. Instead, the Texas law renders the ex-spouse's beneficiary designation ineffective upon divorce unless either:

(1) The decree designates the insured former spouse as the beneficiary; (2) the insured re-designates the former spouse as the beneficiary after rendition of the decree; or (3) the former spouse is designated to receive the proceeds in trust for, on behalf of, or for the benefit of a child or a dependent of either spouse.<sup>81</sup>

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<sup>76</sup> *Id.*

<sup>77</sup> *Id.* (alteration in original).

<sup>78</sup> See OKLA. STAT. tit 15, § 178, (A),(B)(3) (1987).

<sup>79</sup> Whirlpool Corp. v. Ritter, 929 F.2d 1318 (8th Cir. 1991).

<sup>80</sup> LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][C],[D] (citing OKLA. STAT. ANN. tit. 15, § 178).

<sup>81</sup> TEX. FAM. CODE § 9.301(a) (2006) (formerly codified as TEX. FAM. CODE § 3.632(b)); LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][i][C].

Unlike UPC section 2-804 which releases insurer's from liability for wrongful disbursements, the Texas statute holds insurers liable only if: "(1) before disbursing proceeds, it receives written notice from an interested person that the beneficiary is wrong, and (2) it does not interplead and deposit the proceeds into the court registry."<sup>82</sup>

A few major policy reasons exist as to why jurisdictions adopt the minority rule. One argument is that in executing the insurance contract, the policy should be in line with the insured's interest - the divorce itself is evidence of the insured's intent not to have an ex-spouse receive the policy's proceeds. The failure to change beneficiary after a divorce constituted a mere oversight because the execution of a final divorce decree exhibited the insured's true intent to revoke the ex-spouse's beneficiary status. Another policy behind the adoption of these statutes is the inequities that can result from an insured not having time to make a formal beneficiary change after a divorce.<sup>83</sup> Additionally, courts adopting the minority position understand that an insured's failure to make a beneficiary change does not necessarily mean he intended to give the proceeds to his ex-spouse, but rather could have resulted from an inadvertent misunderstanding about the nature of the divorce process in that the divorce itself did not effect a change in beneficiary status.<sup>84</sup>

The minority rule is the more modern rule, in contrast with the traditional majority rule. The minority rule attempts to tackle the issue of deciphering who the deceased's intended policy beneficiary was by assuming the finalized divorce established a clear intent to revoke an ex-spouse's beneficiary status. While this approach likely reflects the current sentiments of divorcing spouses in the twenty-first century, the minority rule, much like the majority rule applies in every situation, is too blunt of a tool to use in such intricate family situations.

#### V. AUTOMATIC REVOCATION STATUTES & THE CONTRACT CLAUSE

A tension exists between a state's retroactive application of an automatic revocation statute that revokes an ex-spouse's beneficiary status to a life insurance contract. Under the federal constitution's Contract Clause, "No State shall . . . pass any . . . Law impairing the Obligation of

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<sup>82</sup> TEX. FAM. CODE § 9.301 (2006); Soliman, *supra* note 57 at 407.

<sup>83</sup> *See, e.g.,* Life Ins. Co. of N. Am. v. Ortiz, 535 F.3d 990 (9th Cir. 2008).

<sup>84</sup> *See* LIFE AND HEALTH INSURANCE, *supra* note 22, at §5.21[1][k][I][iii][A].

Contracts . . . .”<sup>85</sup> The Contract Clause forbids “any interference with contracts” by state law.<sup>86</sup> Under the Contract Clause, “laws which subsist at the time and place of the making of a contract . . . enter into and form a part of it.”<sup>87</sup> These laws typically cannot be changed by ex post facto legislation.<sup>88</sup> Many states that have adopted automatic revocation statutes have retroactively enforced the statutes. The retroactive application of automatic revocation statutes provoked arguments that the state’s involvement substantially impaired a prior, private contractual (here, the life insurance contract) obligation between the named beneficiary and the insurance company.

In its analysis as to whether a state enacted statute is in conflict with the Contract Clause, courts must first establish whether the statute “has operated as a substantial impairment of a contractual relationship.”<sup>89</sup> The inquiry “has three components: whether there is a contractual relationship, whether . . . the law impairs that contractual relationship, and whether the impairment is substantial.”<sup>90</sup> If the court has found that the first two components of substantial impairment existed, it then decides whether a significant and legitimate public purpose exists behind the statute.<sup>91</sup> Lastly, if the court found that a legitimate and significant public purpose existed behind the statute, it must determine whether the state-caused contractual impairment was nevertheless justified as reasonable and necessary in serving an important public interest.<sup>92</sup>

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<sup>85</sup> U.S. CONST. art. I, § 10, cl. 1.

<sup>86</sup> *Honeywell, Inc. v. Minn. Life & Health Ins. Guar. Ass’n*, 110 F.3d 547, 551 (8th Cir.1997).

<sup>87</sup> *Gen. Motors Corp. v. Romein*, 503 U.S. 181, 188 (1992) (citing *Home Building & Loan Assn. v. Blaisdell*, 290 U.S. 398, 429-30 (1934)).

<sup>88</sup> *See also* *MONY Life Ins. Co. v. Ericson*, 533 F. Supp. 2d 921, 928 (D. Minn. 2008).

<sup>89</sup> *Gen. Motors Corp.*, 503 U.S. at 186 (1992) (quoting *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978)).

<sup>90</sup> *Id.*

<sup>91</sup> *See* *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 25 (1977).

<sup>92</sup> *Id.*

## VI. CHALLENGING STATE AUTOMATIC REVOCATION STATUTES THROUGH THE CONTRACT CLAUSE

Many states have found the retroactive application of an automatic revocation statute unconstitutional under the Contract Clause.<sup>93</sup>

While Oklahoma initially retroactively enacted a statute that automatically revoked an ex-spouse's beneficiary status upon divorce unless the insured renames the ex-spouse as beneficiary after divorce, the Oklahoma legislature amended the statute to avoid a Contract Clause issue.

In *Whirlpool Corp. v. Ritter*, the Eighth Circuit found that the retrospective application of Okla. Stat. tit. 15, § 178(B)(6) violated the Contract Clause.<sup>94</sup> Again, an insured did not change his ex-spouse's primary beneficiary status after their divorce before he died.<sup>95</sup> In examining whether the Contract Clause prohibited the state from retroactively passing the statute Okla.Stat. tit. 15, § 178(B)(6), the Eighth Circuit reasoned that the insured was entitled to expect that his wishes regarding the insurance proceeds (per the then-existing law) would be effectuated.<sup>96</sup> By retroactively applying the automatic revocation statute, the State impaired the insured's contract by reaching back in time and disrupting this expectation.<sup>97</sup> Finding the impairment significant, the statute impeded the primary purpose of forming the contract – mainly to provide for the people of the insured's choosing in the event of his death.<sup>98</sup> In next analyzing whether the State's impairment of the contract was with legitimate purpose and done in a reasonable manner, the court found that while the statute intends to effectuate a change in beneficiary because a fundamental family change had occurred and a tendency to overlook the formality of changing beneficiary status frequently occurred, retroactively applying the statute those who entered into contracts before the legislation passed may frustrate the insured's intent to provide for his designated

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<sup>93</sup> See, e.g., *Whirlpool Corp. v. Ritter*, 929 F.2d 1318, 1322 (8th Cir. 1991); *Scott v. Pub. Sch. Ret. Sys. of Missouri*, 09-4241-CV-C-NKL, 2010 WL 3749210, \*12 (W.D. Mo. Sept. 21, 2010); *MONY Life Ins. Co.*, 533 F. Supp. 2d at 928 (D. Minn. 2008); *Maddux v. Philadelphia Life Ins. Co.*, 77 F. Supp. 2d 1123, 1128 n.1 (S.D. Cal. 1999); *In re Estate of Holycross*, 858 N.E.2d 805, 809 (Ohio 2007); *Paronese v. Midland Nat. Ins. Co.*, 706 A.2d 814, 816 (Pa. 1998).

<sup>94</sup> See also *Whirlpool Corp.*, 929 F.2d 1318.

<sup>95</sup> See also *id.*

<sup>96</sup> *Id.*

<sup>97</sup> *Id.* at 1322.

<sup>98</sup> *Id.*

beneficiary.<sup>99</sup> The court held that the statute, when retroactively applied, violated the Contract Clause.<sup>100</sup>

In 1998, a Pennsylvania court reviewed the same issue regarding a retroactively applicable Pennsylvania automatic revocation statute<sup>101</sup> in *Paronese v. Midland National Insurance Company*.<sup>102</sup> Here, the ex-spouse primary beneficiary of a life insurance policy brought an action against an insurer and the contingent beneficiaries to recover benefits following divorce from insured.<sup>103</sup> The Pennsylvania Supreme Court, like in *Whirlpool*, found that the retroactive application of such a statute violated the Contract Clause. In its Contract Clause analysis, the Court found that the retroactive application the statute undermined “the very essence of [insured’s] contract”<sup>104</sup> and that the state neither had an emergency need to protect this small group nor was the retroactive application of the law protecting a basic societal interest.<sup>105</sup>

In *Scott v. PSRS*,<sup>106</sup> a district court took an even broader view in holding that the automatic revocation statute violated the Contract Clause pertaining to an independent contract for retirement benefits, not a formal life insurance policy. An ex-spouse brought an action alleging a violation of the Contract Clause seeking money damages based on the refusal to pay certain death benefits after her ex-husband died but did not change the plaintiff’s beneficiary designation status after their divorce.<sup>107</sup> The court

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<sup>99</sup> *Id.* at 1323 (“While it may be true that some individuals, given a choice, would prefer to guaranty the financial security of their new family instead of their former family, this is certainly not a universal truth.”).

<sup>100</sup> *See also Whirlpool Corp.* 929 F.2d at 1323-4, n.6 (alteration in original) (citing *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 19-20 n.17 (1977) (“However, [the Eighth Circuit] note[d] that, for purposes of the contracts clause, there [wa]s a profound difference between changing the law directly governing contracts yet to be made and changing the law directly governing contracts that have already been made. In the former case, the parties can be expected to incorporate the changes into their planning and negotiating, whereas in the latter case the parties expect their bargain to be protected in accordance with the law existing at the time of their agreement.”).

<sup>101</sup> 20 PA. CONS. STAT. § 6111.2 (1994).

<sup>102</sup> *Paronese v. Midland Nat. Ins. Co.*, 706 A.2d 814 (Pa. 1998).

<sup>103</sup> *Id.*

<sup>104</sup> *Id.* at 818 (alteration in original).

<sup>105</sup> *See id.* at 818-19.

<sup>106</sup> *Scott v. PSRS*, No. 09 4241 CV C NKL, 2010 WL 3749210 (W.D. Mo. Sept. 21, 2010).

<sup>107</sup> *Id.* at \*3.

noted that under Section 169.076 of the Missouri Revised Statutes,<sup>108</sup> the insured's existing beneficiary designation had been "automatically and retroactively revoked by operation of Missouri law due to divorce" and the plaintiff ex-spouse was "no longer entitled to the benefits."<sup>109</sup>

In analyzing the merits of the Contract Clause claim, the Court held that, relying on *Whirlpool* as precedent, "a party designating a beneficiary was entitled to expect that his . . . wishes – as expressed in a contract which pre-dated the divorce revocation statute- would be honored" and that "disrupting that expectation, the statute substantially impaired the contract."<sup>110</sup> Even though the court noted the death benefits in this case were in fact "a contract concerning post-death retirement proceeds" and not a formal life insurance policy, the similarities in intending to provide for the insured's family after his death were substantial enough for this case to be encompassed under the Eighth Circuit's existing rule that the revocation statute could not be applied to a pre-existing contract.<sup>111</sup>

Most recently, a court held Minnesota's automatic revocation statute, § 524.2-804,<sup>112</sup> unconstitutional.<sup>113</sup> In *MONEY*, the insured's ex-spouse sought a declaration from the court that he was entitled to his ex-spouse's insurance proceeds.<sup>114</sup> The court, relying on *Whirlpool*, found that under the Contract Clause, substantial impairment existed in the contractual relationship between the insured and the insurer and the purpose behind Minnesota's statute, that ex-spouses often intend to change their beneficiaries, cannot be used to justify the fundamental change to the existing life insurance contract.<sup>115</sup> Most interestingly, although *MONEY* held the retroactive application of the statute unconstitutional, just a year prior

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<sup>108</sup> MO. REV. STAT. 169.076.2 (2005) ("The member's marriage, divorce, withdrawal of accumulated contributions, or the birth of the member's child . . . shall result in an automatic revocation of the member's previous designation in its entirety upon the retirement system receiving actual notice of such event before or after the member's death and prior to any payment being made under the provisions of this chapter.").

<sup>109</sup> *Scott*, 2010 WL 3749210, at \*3.

<sup>110</sup> *Id.* at \*12 (citing *Whirlpool Corp. v. Ritter*, 929 F.2d 1318, 1322 (8th Cir. 1991)).

<sup>111</sup> *Id.*; see *Whirlpool*, 929 F.2d at 1323.

<sup>112</sup> MINN. STAT. § 524.2-804 (2002).

<sup>113</sup> *MONEY Life Ins. Co. v. Ericson*, 533 F. Supp. 2d 921 (D. Minn. 2008).

<sup>114</sup> *Id.*

<sup>115</sup> *Id.* at 924-25.

another Minnesota District Court held the retroactive application of the statute constitutional.<sup>116</sup>

Other courts analyzing the retroactive application of automatic revocation statutes have found that no Contract Clause issue existed because an ex-spouse's beneficiary designation prior to divorce did not create a vested contractual right in the ex-spouse sufficient to allege a Contract Clause challenge.<sup>117</sup> This division in the constitutionality of the statutes adds to the confusion in this area of law.

## VII. PROPERTY SETTLEMENT AGREEMENT EXCEPTION

When beneficiary status issues arise in both majority and minority jurisdictions, the court typically will examine the terms of the property settlement agreement or divorce decree to decipher whether the terms of the agreement or decree provide sufficient clarity of the insured's intent to divest his ex-spouse of her beneficiary status. Some jurisdictions allow the terms of a property settlement agreement, if sufficiently explicit, to act as a change in beneficiary status without formally changing the beneficiary through the terms of the insurance policy. These states examine the precise wording of the property settlement agreement, when the insured purchased the insurance policy and what the surviving ex-spouse specifically waived in order to determine whether the property settlement exception to either the majority or minority rule applied.<sup>118</sup>

Some majority jurisdictions do not recognize this exception, holding that a release in a property settlement agreement is not sufficient to override the insurance contract language.<sup>119</sup> In contrast, some minority

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<sup>116</sup> See generally *Lincoln Benefit Life Co. v. Heitz*, 468 F. Supp. 2d 1062, 1063, 1067 (D. Minn. 2007) (holding that a nonexistent Contract Clause issue because an ex-spouse's beneficiary designation prior to divorce did not create a vested contractual right in the ex-spouse sufficient to allege a Contract Clause challenge).

<sup>117</sup> See, e.g., *Stillman v. Teachers Ins. & Annuity Ass'n Coll. Ret. Equities Fund*, 343 F.3d 1311, 1322 (10th Cir. 2003); *Allstate Life Ins. Co. v. Hanson*, 200 F. Supp. 2d 1012, 1019 (E.D. Wis. 2002); *Estate of DeWitt v. DeWitt*, 54 P.3d 849 (Colo. 2002); *Mearns v. Scharbach*, 12 P.3d 1048, 1056 (Wa. Ct. App. 2000).

<sup>118</sup> See Jani Maurer, *Use and Disposition of Life Insurance in Dissolution of Marriage*, 16 BARRY L. REV. 57, 109 (2011).

<sup>119</sup> The most notable example of a majority jurisdiction that does not apply this exception, even for unambiguous property settlement agreements, is Florida. Soliman, *supra* note 57, at 407.



jurisdictions allow the insured to execute his intent for an ex-spouse to remain the beneficiary of his life insurance policy despite the automatic revocation statute if his intent is clearly expressed in a property settlement agreement.<sup>120</sup> For example, although the New Jersey legislature enacted a divorce revocation statute, the courts have adopted an exception to the statute that allows for divorcing spouses who have entered into a property settlement agreement which purports to “wipe the slate clean” between them, divorce creates a presumption that designation of either of the spouses as the beneficiary of the other’s life insurance policy has been revoked.<sup>121</sup> A New Jersey court first held that the state had joined “the overwhelming number of states that have enacted statutes recognizing revocation by divorce. Those statutes adopt the presumption that ‘in the vast majority of cases the testator’s failure to revoke his will subsequent to a divorce is due to neglect . . .’” in 1978.<sup>122</sup> In 1991, the New Jersey Supreme Court adopted the presumption that when the agreement supposedly covers all property rights, the insured’s intent per the agreement is to revoke or keep the existing designation of a spouse as beneficiary.<sup>123</sup>

Different state standards exist as to whether the decree or settlement meets the specificity required for the property settlement exception to apply. Some states decide whether the settlement may be reasonably construed as a relinquishment of an ex-spouse’s beneficiary status.<sup>124</sup> Other states examine whether wording of the agreement on the whole appears to indicate the intention of relinquishment.<sup>125</sup> Another standard adopted by states is whether the agreement expressly states the intent to deprive the ex-spouse of her beneficiary status.<sup>126</sup>

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<sup>120</sup> See *e.g.*, *Vasconi v. Guardian Life Ins. Co.*, 590 A.2d 1161 (N.J. 1991).

<sup>121</sup> *Id.* at 1165-66 (citation omitted).

<sup>122</sup> *Id.* at 1164 (citation omitted).

<sup>123</sup> *Id.* at 1164-66.

<sup>124</sup> See, *e.g.*, *Beneficial Life Ins. Co. v. Stoddard*, 516 P.2d 187 (Idaho 1973); *Hollaway v. Selvidge*, 548 P.2d 835 (Kan. 1976); *Prudential Ins. Co. v. Weatherford*, 621 P.2d 83 (Or. Ct. App. 1980).

<sup>125</sup> See *Costello v. Costello*, 379 F. Supp. 630 (D. Wyo. 1974) (applying Wyoming law); *Life Ins. Co. of N. Am. v. Cassidy*, 676 P.2d 1050 (Cal. 1984) (en banc); *Redd v. Brooke*, 604 P.2d 360, 361 (Nev. 1980); *Pitts v. Ashcraft*, 586 S.W.2d 685 (Tex. Civ. App. 1979); *Culbertson v. Cont’l Assurance Co.*, 631 P.2d 906 (Utah 1981).

<sup>126</sup> See *Metro. Life Ins. Co. v. Frawley*, 712 F. Supp. 131, 133 (S.D. Ohio 1989) (applying Ohio law).

In Washington, for the property settlement exception to revoke an ex-spouse's beneficiary status, the decree must expressly divest the ex-spouse of any expectancy under the policy and a beneficiary change within a reasonable time must exist for the designated ex-spouse to lose her right to the proceeds.<sup>127</sup>

The property settlement agreement exception, likely a response to the blunt application of the existing majority and minority rules, provides a way for certain situations to opt out of the existing jurisdictional rule, while still executing the insured's intent. Each state can tailor the required level of specificity for the property settlement agreement exception to what it views as clear evidence of the insured's intent.

#### VIII. CONCLUSION: HOW TO DEVELOP MORE COHERENT RULES IN THIS AREA OF LAW

The recent split of authorities in minority jurisdictions regarding the retroactive application of automatic revocation statutes only adds confusion to the existing dichotomy between majority and minority jurisdictions and jurisdictions that have adopted the property settlement agreement exception, contributing to more uncertainty as to whether or not an ex-spouse still named as a beneficiary after having divorced the insured will receive the policy's proceeds. In this area, the courts must balance the need to execute the insured's intent, while upholding the nature of the insurance contract. Because this issue arises only after the insured died and can therefore no longer state his intended beneficiary, it remains more important for clearer case law to exist regarding this matter when proactive legal counseling can no longer help.

While the modern trend of adopting automatic revocation statutes addresses the growing trend of asset transfer through nonprobate financial instruments rather than the slow moving probate process,<sup>128</sup> the majority rule of upholding the existing text of the insurance contract executes a verifiably true intent of the insured. In an attempt to garner more consistent

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<sup>127</sup> *Aetna Life Ins. Co. v. Wadsworth*, 689 P.2d 46 (Wash. 1984).

<sup>128</sup> See generally John Langbein, *The Nonprobate Revolution and the Future of the Law of Succession*, 97 HARV. L. REV. 1108 (1984) (Suggesting the development of nonprobate financial instruments as the primary means of transferring wealth as basis for legitimating the main will substitutes as "nonprobate wills" and for unifying the constructional law of wills and will substitutes).

case law on this issue, I would encourage legislatures enacting automatic revocation statutes to at least avoid potential Contract Clause issues altogether by not retroactively applying the statute. Retroactive application of automatic revocation statutes only confuses an already dizzying area of law.

Because of the pivotal nature of life insurance in providing for families in the event of the death of a primary wage earner<sup>129</sup>, ensuring the policy's proceeds go to the correct beneficiary is the purpose of obtaining the policy. Compounding on life insurance's role in providing for loved ones in the event of the insured's death is the difficulty in not only not having the correct beneficiary receive the policy's benefits, but also having an ex-spouse receive policy's proceeds.

In most instances, the determination of a policy's actual beneficiary can take a substantial amount of time when insurance companies must interplead both primary and contingent beneficiaries in a lawsuit. Courts and state legislatures should recognize life insurance's role of providing immediate financial aid to families who have just suffered a loss when determining whether to adopt either the majority or minority rule in their jurisdiction or change existing precedent.

While legislatures and courts adopting either majority or minority rule need to instill a sense of uniformity and equity to decisions in this area of law, the role of life insurance in conjunction with the intricacy and variation of each couple's divorce proceedings require the court to take a closer look at these matters. The court needs to decipher whether an omission in a change of beneficiary after a divorce is a mistake of legal form, and if so, whether the court can and should correct this mistake. Ultimately, courts and legislatures are trying to address the intent issue.

Compelling policy reasons exist on both majority and minority opinions on this issue. If a state wants to adopt the modern trend of the minority rule by passing an automatic revocation statute, the action should preferably come from the legislature to better represent the constituent consensus and prevailing societal views on the relationships of ex-spouses upon divorce. Either the majority rule of upholding the letter of the insurance contract or the minority rule revoking an ex-spouse's beneficiary status applies as a default rule. However, the often intricate relationship dynamic between divorced couples along with how and when the insured's

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<sup>129</sup> *Life Insurance Is Key Component of a Family Financial Plan*, INS. INFO. INST. (Nov. 5, 2010), [http://www.iii.org/press\\_releases/life-insurance-is-key-component-of-a-family-financial-plan.html](http://www.iii.org/press_releases/life-insurance-is-key-component-of-a-family-financial-plan.html).

policy was executed require the court to look closer to decipher the insured's intent. Because the court is ultimately trying to decipher intent, all states should adopt the property settlement exception. The property settlement agreement, as a part of the divorce process, best captures the insured's intent on what he did or didn't intend to give over to his ex-spouse. Because the property settlement agreement is executed when both parties are represented by counsel, the court should recognize the insured's intent as evidenced by a higher level of specificity from the property settlement exception over whatever the existing jurisdictional rule is. If the insured meets a higher threshold of proof that he either did or didn't intend to have his ex-spouse remain his life insurance beneficiary, the court should recognize this higher level of intent regardless of the existing jurisdictional rule.

If the insured's property settlement agreement meets the required level of specificity to opt out of the existing jurisdictional rule, the courts should accept that. This would allow the court, in certain instances where the insured clearly intended (the guidelines about what level of specificity should be outlined by the legislature) the opposite of what the existing jurisdictional rule dictated, to better match the insured's intent.

The courts and legislatures should have two goals in mind when dealing with this area of law: executing the insured's intent and uniformity. The court should try to get the policy's proceeds to the correct persons while also uniformly applying the jurisdictional rule in order to give a greater sense of certainty to those in the jurisdiction looking to challenge the insurance company's disbursement of a deceased's life insurance policy proceeds to an ex-spouse. This would not only allow for quicker resolutions and fulfill one of the purposes of a non-probate asset like life insurance – to quickly transfer wealth outside of the lagging probate system to the intended beneficiary. State legislatures' retroactive application of automatic revocation statutes interfere with the uniform applicable of the state's rule in this area of law. Because of the Contract Clause issue, states that choose to adopt the modern minority rule should avoid making them retroactively applicable because the issue incites more challenges to an insurance company's dispersal of a policy's proceeds, creating more unsettlement in an already murky area of law.



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